

STATE OF MICHIGAN  
IN THE COURT SUPREME COURT

RITA KENDZIERSKI, BONNIE HAINES,  
GREG DENNIS, LOUISE BERTOLINI,  
JOHN BARKER, JAMES COWAN,  
VINCENT POWIERSKI, ROBERT STANLEY,  
ALAN MOROSCHAN, and GAER GUERBER,  
on behalf of themselves and those who are  
similarly situated,

Supreme Court No.

Court of Appeals  
No. 329576

Macomb County Circuit Court  
No. 10-001380-CK

Plaintiffs-Appellees

v

COUNTY OF MACOMB,

Defendant-Appellant.

**APPLICATION FOR LEAVE TO APPEAL AND BY DEFENDANT-APPELLANT  
COUNTY OF MACOMB**

**NOTICE OF FILING SUPREME COURT APPLICATION**

**EXHIBITS**

**CERTIFICATE OF SERVICE**

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**STATEMENT IDENTIFYING THE JUDGMENT AND ORDERS  
APPEALED FROM**

This is a class action filed on March 31, 2010, on behalf of certain retirees of Macomb County. The plaintiffs asserted that retirees' healthcare benefits were vested, and that in 2009 and 2010, the County had improperly reduced benefits in violation of collective bargaining agreement(s). (Complaint) The Court of Appeals in a published opinion issued on April 18, 2017, authored by Judge Kathleen Janson, and concurred in by Judges Karen Fort Hood, and Joel Hoekstra, held that, under Macomb County's multitude of collective bargaining agreements covering the periods from 2000 to 2010, "retiree healthcare benefits are vested." (Opinion, p 5) The Court of Appeals denied the County's motion for reconsideration, filed on May 8, 2017, by order of May 30, 2017.

The Macomb County Circuit Court, by the Honorable Diane M. Druzinski, in an opinion and order entered September 16, 2015, had denied plaintiffs' motion for summary disposition, and granted the County's motion for summary disposition, holding that retiree healthcare benefits were vested for their lifetime, but that the County could make reasonable modifications to those benefits, such that there had been no breach of the collective bargaining agreements by the County. The Court of Appeals in its April 18, 2017, opinion directed the Macomb County Circuit Court to grant plaintiffs' motion for a permanent injunction and motion for summary disposition, and to deny the County's motion for summary disposition. (Opinion, p 6)

Macomb County seeks leave to appeal from, or peremptory reversal of, the April 18, 2017, opinion and judgment of the Court of Appeals, and the September 16, 2015, opinion and order of the Macomb County Circuit Court.

**PRELIMINARY STATEMENT BY THE COUNTY REGARDING IMPORTANCE OF  
THIS APPEAL, MCR 7.305(B), AND THE COUNTY'S INTENT**

The Court of Appeals in its published opinion has held that where a collective bargaining agreement is silent as to vesting of retiree health care benefits, an ambiguity allowing resort to extrinsic evidence as to vesting exists in common CBA provisions setting forth events that will modify a retirees' benefits during the contract period. This determination is, the County submits, directly in violation of fundamental canons of contract interpretation, and the declaration of Michigan's appellate courts, in agreement with the U.S. Supreme Court, in *M&G Polymers USA, LLC v Tackett*, 574 US\_\_\_; 135 S Ct 926; 190 L Ed 2d 809 (2015), that vesting of retiree healthcare benefits may not be inferred from the silence of a collective bargaining agreement.

As set forth in the argument below, the issues raised by the application in this case against Macomb County, as a subdivision of the state, have significant public interest, MCR 7.305(B)(2), involve legal principles of major significance to the state's jurisprudence with respect to interpretation of collective bargaining agreements on the critical question of vesting, MCR 7.305(B)(3), and involve a decision of the Court of Appeals that is clearly erroneous and will cause material injustice, MCR 7.305(B)(5)(a).

This appeal is about legal issues of contractual obligations, and whether, as a matter of contract, the County is forever required to provide specific benefits from specific carriers to its retirees, at the risk of facing litigation and a damages judgment if it does not provide those specific benefits.

Notwithstanding the legal issues, however, the County wishes to make clear that it will make every effort to continue to provide its retirees with quality healthcare benefits, and at this time sees no reason why it should not be able to do so. The County has taken extraordinary steps of investing more than a quarter of one billion dollars in a trust to assure

that future funds will be available to pay for retiree healthcare. The County seeks only to preserve the flexibility to shop the commercial health care markets to get the most competitive rates available while maintaining the same level of benefits for the retirees.

To paraphrase the Sixth Circuit Court of Appeals in *Gallo v Moen Inc*, 813 F3d 265 (CA 6, 2016), discussed *infra*, the fact that the County “to its credit hopes to subsidize healthcare benefits for its retirees for as long as possible” and has undertaken responsible fiscal steps to enable it to do so, “does not mean . . . that it has no right to alter those benefits in the future. . . .” To protect the rights of all of its employees and retirees, and ensure its ability to continue to provide quality healthcare benefits to retirees in the future, the County must retain the right to make reasonable and fiscally responsible modifications to those benefits.

## QUESTIONS PRESENTED FOR REVIEW

### I

**Whether The Court Of Appeals Clearly Erred In Holding That Retiree Healthcare Benefits Under Macomb County Collective Bargaining Agreements Are Vested, And Unalterable For The Retirees' Lifetimes, Except With The Retirees' Consent, Where The Agreements Are Silent, And Unambiguous, As To Vesting, Such That Resort To Extrinsic Evidence To Find Vesting Is Thus Improper?**

### II

**Whether Alternatively, Even Assuming Arguendo, That The Collective Bargaining Agreements Were Ambiguous With Respect To Whether Retiree Healthcare Benefits Were Vested, The Court Of Appeals Clearly Erred In Holding That, As A Matter Of Law, Extrinsic Evidence Established An Agreement That The Benefits As Described In The CBAs Were Vested And Unalterable Without Consent, Such That, At A Minimum A Question Of Fact Remains For The Trier of Fact?**

### III

**Whether Regardless Of Whether Retiree Healthcare Benefits Vested, The Court Of Appeals Erred In Ordering That Plaintiffs' Motion For Summary Disposition Be Granted, Where Plaintiffs Failed To Demonstrate A Genuine Issue Of Material Fact As To A Breach Of The CBAs By Virtue Of The Changes To Healthcare Insurance (Except As To Prescription Drug Coverage For Non-Medicare Eligible Retirees), Implemented By The County In 2009 And 2010?**

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## **STATEMENT OF FACTS**

### **Underlying Facts**

Plaintiffs are a class of approximately 1,600 retirees (less those that have opted out) who formerly worked for defendant County of Macomb (the “County”) pursuant to numerous collective bargaining agreements (“CBAs”) dating back to 1989, and who receive County health insurance benefits. There are approximately 23 different CBAs between the County and its employees, each of which is in effect for a 3 year period, and which contain a variety of terms related to retiree healthcare. (Exhibit F to defendant’s motion for summary disposition (“MSD”), Herppich dep, p 107)

The complaint consists of a single breach of contract claim in which plaintiffs allege that they have vested lifetime healthcare benefits. Plaintiffs assert that defendant disregarded its alleged obligations under the CBAs “by unilaterally reducing and/or improperly altering this contractually required retirement healthcare.” (Complaint, ¶ 22) The retirees “challenge the County’s unilateral healthcare reductions imposed in 2009 and 2010.” (Plaintiffs’ response to MSD, p 2) Specifically, they allege that defendant increased prescription drug co-payments in 2009, and implemented benefit changes and reductions in 2010. (Complaint, ¶¶ 22-25). While plaintiffs in the complaint pled that they are entitled, in perpetuity, to that level of healthcare described in the CBA in place at the time of their respective retirements, they have instead argued below and on appeal that the changes in 2009 and 2010 violated only the terms of the CBAs in effect at that time, those covering the 2008-2010 period.

Defendant conceded that alterations were made to retiree healthcare benefits in 2009 and 2010, but submitted that these alterations were consistent with the applicable CBAs that had been negotiated between the County and the unions on behalf of active employees, and in effect from 2008 to 2010. Defendant further submitted that the prior

CBAs did not grant vested or lifetime healthcare benefits to retirees.

### **Pre-2008 CBAs**

From 1989 to present, CBAs between the County and its employees were negotiated with multiple unions, with each CBA in effect for a specific 3 year period; all CBAs in effect in a given three year period were substantially the same, for purposes of the issues in this case. The CBAs in effect from January 1, 2005 through December, 31, 2007, like those before and after, provided that they were in effect for a period of 3 years, until the end of the contract period, at which time they could be terminated or modified. (See exhibit 3 to plaintiff's motion for summary deposition, exemplar, complete 2005-2007 CBA between Macomb County And AFSCME Local 411, Article 39, Termination or Modification, p 40, excerpts attached as appeal exhibit B) The termination or modification provision in the CBAs was:

#### **Termination or Modification**

- A This Agreement shall continue in full force and effect until December 31, 2007.
- B. If either party wishes to terminate or modify this Agreement, said party shall provide written notice to the other party to that effect. Said notice shall be made no later than one hundred twenty (120) days prior to the termination date in Paragraph A, above. If neither party files a notice of termination or modification, or if each party giving notice of termination or modification withdraws said notice prior to the termination date in Paragraph A, above, this Agreement shall continue in full force and effect from year to year thereafter, subject to timely notice of termination or modification by either party in subsequent year(s) of an extended Agreement. [2005-2007 CBA, Article 39, p 40]

Each of the CBAs on their face sheet stated they were in effect for a specific three year period, with a beginning date and an end date. (See e.g., "Agreement Between County Of Macomb And American Federation Of State, County And Municipal Employees, Local 411, January 1, 2005 through December 31, 2007," exhibit D)

Like previous CBAs, the 2005 through 2007 CBAs set forth provisions regarding Insurance Benefits for both active employees, and retirees, in Article 19, exhibit B at pp 18-22. With respect to retirees, the 2005-2007 agreement provided for “fully-paid Blue Shield/Blue Shield Hospital-Medical coverage, or its substantial equivalence,” and specified the amount of various copays for “the employee who leaves employment because of retirement and is eligible for and receives” retirement benefits:

2. Retirees. The Employer will provide fully paid Blue Cross/Blue Shield Hospital-Medical coverage to the employee and the employee’s spouse, after eight (8) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees’ Retirement Ordinance, based upon the following conditions and provisions: [identifying specific coverages] \* \* \* [Exemplar 2005-2007 CBA, appeal exhibit B, p 20)]

Healthcare coverage in that 2005-2007 CBA for retirees was specified to be “Blue Cross/Blue Shield MVF1 Master Medical,” “or its substantial equivalence.” (*Id*, p 20) The employer was also to offer an HMO. (*Id*) Retirees upon reaching age 65 were required to participate in Medicare, at which time “the Employer’s obligation shall be only to provide ‘over 65 supplemental’ hospital-medical coverage.” (*Id*, p 20) This was the only obligation stated in the CBAs for Medicare-eligible retirees.

None of the CBAs have ever provided that healthcare coverage for retirees was “vested” or “lifetime,” or provided a specific period of duration, other than as provided on the CBA face sheet, and in the CBA article on termination or modification after the three year period in which the CBA was in effect. (See e.g., 2005-2007 CBA, appeal exhibit D; see also excerpts of healthcare benefits provisions from all CBAs, exhibit 2 to plaintiffs’ motion for summary disposition)

### 2008-2010 CBAs

As in prior years, new three-year CBAs were negotiated to become effective for a three year period after the termination of the 2005-2007 CBAs. See exemplar “Agreement Between County Of Macomb And American Federation Of State, County And Municipal Employees, Local 411, January 1, 2008 through December 31, 2010,” exhibit B to defendant’s motion for summary disposition, attached as appeal exhibit E)

The 2008 – 2010 CBAs in Article 19(B) provided that the County would provide active employees, and non-Medicare eligible retirees, with Blue Cross/Blue Shield Preferred Provider (PPO) coverage (instead of the Blue Cross/Blue Shield MVF1 Master Medical, previously specified in the 2005-2007 CBAs), and HMO coverage. Article 19(B) stated in part:

#### ARTICLE 19

#### INSURANCE BENEFITS

\* \* \*

#### B. Hospital-Medical Insurance:

1. Active Employees (including DROP Participants): The Employer shall provide fully paid Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence and Health Maintenance Organization (HMO) coverage or its substantial equivalence to all regular employees and their eligible family members, including prescription drug coverage, as outlined in Appendix D.

\* \* \*

2. Retirees: The Employer will provide fully paid **Blue Cross/Blue Shield Preferred Provider Organization (PPO)** coverage or its substantial equivalence to the employee and the employee’s spouse, after eight (8) years of service with the employer, for the Employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees’ Retirement Ordinance [pension plan], **based upon the following conditions and provisions:** \* \* \* [Appeal exhibit E, emphasis added]

The CBAs also provided that the Employer was to provide retirees with an HMO option, provided that the premium does not exceed the cost of present insurance. (Exemplar policy, appeal exhibit E)

Appended to the 2008 – 2010 CBAs was Appendix D, referenced in the coverage provision for active employees (but not retirees), that outlined coverage provided by the Community Blue PPO Plan 6. This “fully paid” Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage included deductibles and copays. (*Id*)

### **Past Changes to Healthcare Benefits**

Prior to the benefits changes in 2009 and 2010 challenged by plaintiffs in this matter, the County had modified retiree healthcare benefits on many occasions. Examples of historical changes to retiree healthcare benefits are as follows:

- In 1988, retirees covered by Blue Cross Blue Shield (“BC/BS”) could now select PPO coverage
- In 1989, defendant’s Board of Commissioners advised it would offer fully paid healthcare to all county retirees and/or their spouses regardless of the year they retired.
- In 1990, retirees were offered dental (with an \$800 maximum) and optical at the same levels of coverage as employees with a 25% premium sharing for retiree and 100% premium sharing for spouse.
- In 1996, non-Medicare eligible retirees were offered BC/BS PPO
- In 2002, the retirees enrolled in PPO and Traditional were given the option to purchase hearing coverage.
- In 2003, a PPO was made available to Medicare eligible retirees and prescription co-pays for all non-HMO retirees increased from \$2 to \$5.
- In 2005, Medicare-eligible were offered BC/BS PPO
- In 2006, retirees using mail order prescriptions had their co-pays increase from \$2 to \$5. [Defendant’s MSD exhibits B, C, M, Human Resource’s Bulletins re changes in benefits]

No litigation or challenge ensued with respect to these changes, and the retirees have admitted that they never complained of these changes. (See e.g. Defendant's MSD exhibit D, Bertolli dep, p 30; MSD exhibit E, Cowan dep, pp 23-25, 54)

### **2009 And 2010 Changes To Healthcare Benefits Challenged By Class**

During the 2008-2010 CBA contract period, various changes to retiree healthcare coverage were implemented by the County. Though not previously challenging prior healthcare changes, the retiree class in this matter has alleged that these changes breached the 2008-2010 CBAs. The trial court ultimately rejected this claim, on the ground that unilateral changes to contracted-for benefits were permissible, if reasonable, but the Court of Appeals, apparently accepted this claim, given its directive that plaintiffs' motion for summary disposition be granted.

**2009 Prescription Co-Pay Changes for Non-Medicare Eligible Retirees.** In 2009, the prescription co-pay under the BC/BS Traditional and BC/BS PPO plans were changed from a flat \$5 co-pay to a \$0/\$10/\$20 co-pay, depending on whether the prescription was generic, formulary or non-formulary, respectively. (Defendant's MSD exhibit G, notification of new prescription drug program) The co-pay under Health Alliance Plan ("HAP") and Blue Care Network changed from a \$2 co-pay to a \$5/\$10/\$20 co-pay. (*Id*) Based upon the new coverage options, the amount of the retiree co-pays actually decreased for many retirees whenever a generic drug could be utilized, and only increased slightly if a generic drug was not available. (Defendant's MSD exhibit I, Gelman 7/9/15 affidavit) (For purposes of this application, defendant is not challenging whether these changes, only, were consistent with 2008-2010 CBAs as to non-Medicare eligible retirees.)

**2010 Plan Changes for Medicare Eligible Retirees.** In 2010, Medicare-eligible retirees received a supplemental health plan from United American Insurance Company

(administered by AmWins). (Defendant's MSD exhibit I, Gelman affidavit) The prior options for Health Alliance Plan, Blue Care Network, BCBS PPO and BCBS Traditional were eliminated. Many coverages actually improved. (Defendant's MSD exhibit H, Summary plan comparisons for 2009 and 2010 plans for Medicare eligible, MSD exhibit I Gelman affidavit)

Defendant continues to submit that these changes were consistent with the CBAs, because as set forth in Argument III, below, Medicare eligible retirees were entitled only to "over 65 supplemental" hospital-medical benefit coverage, which was not affected by these changes.

**2010 Plan Changes for Non-Medicare Eligible Retirees.** Non-Medicare eligible retirees were transitioned to Blue Cross/Blue Shield of Michigan PPO 6 or Blue Care Network HMO. The Blue Cross Traditional, Community Blue PPO 5, and Health Alliance Plan HMO were eliminated. Retirees transitioning from HMO to HMO continued to have the same services covered. (Defendant's MSD exhibit J, Summary plan comparisons for 2009 and 2010 plans for non-Medicare eligible) As detailed in the argument below, some deductibles increased, but various coverages also increased. With the HMO option there was no deductible and no co-insurance. (*Id*) Nor was there any reduction in coverage for retirees who transitioned from Community Blue PPO Plan 5 to Community Blue PPO Plan 6. With respect to coverage of preventative services, there were no longer any age restrictions on mammograms. (Defendant's MSD exhibit I, Gelman affidavit, Defendant's MSD exhibit J, Summary plan comparisons for 2009 and 2010 plans for non-Medicare eligible) Prescription coverage remained the same for all non-Medicare eligible retirees. (*Id*)

Defendant continues to submit that these changes were consistent with the CBAs, because as set forth in Argument III, below, they were entitled thereunder only to "Blue

Cross/Blue Shield Preferred Provider Organization (PPO) Coverage,” and an HMO Option, both of which were provided; further coverage remained “fully paid.”

**Cross Motions For Summary Disposition And Trial Court Opinion**

The trial court bifurcated discovery, limiting it to liability, and not allowing discovery regarding damages. The parties each filed motions for summary disposition, that were decided by the trial court by opinion and order entered on September 16, 2015. (Appeal exhibit C) The trial court first held that the language of the various CBAs was unambiguous regarding retiree healthcare coverage, and that the CBAs did not provide a certain duration or level of retiree healthcare coverage beyond the term of each CBA:

There is no ambiguity in the plain language regarding retiree healthcare coverage in the various CBAs. The CBAs only require defendant to provide healthcare coverage to retirees. Defendant did not promise or otherwise obligate itself under the clear language to provide a certain duration or level of retiree healthcare coverage beyond the term of each CBA. Indeed, plaintiffs have not pointed to any specific CBA language explicitly conferring lifetime or unalterable healthcare benefits on retirees. [Opinion, pp 9-10, footnote 3 omitted]

The trial court further held, however, that plaintiffs had established, by extra contractual statements by County representatives, that the County had a “custom” of providing lifetime benefits, but that there were no representations that the level of coverage was unalterable:

Notwithstanding, plaintiffs have proffered unrefuted evidence that defendant has acknowledged that retiree healthcare coverage is a lifetime benefit. The Retiree Healthcare, Capital Improvement Plan and Downtown Revitalization Funding Proposal issued by Macomb County Executive Mark A. Hackel unmistakably states defendant “provides retiree health benefits to eligible County retirees (and their eligible beneficiaries) for their *lifetimes*.” *Id.* at 28. (emphasis added). Consistent therewith, John Barker testified that Wendy Fisher told him that his retiree medical coverage was a lifetime benefit. Consequently plaintiffs have proven that defendant has a custom of providing lifetime health coverage.

However, plaintiffs have not established that defendant unequivocally acknowledged that it is obliged to provided [sic] unalterable retiree healthcare

coverage. \* \* \* In the same way defendant's various acknowledgments of "obligations", without reference to any specific promise regarding a vested minimum level of retiree healthcare coverage, does not establish defendant admitted the coverage was unalterable. [Opinion, pp 10, 11]

Finally, the trial court held that plaintiffs had failed to establish a breach of contract, but that the County was obligated to provide retirees with lifetime healthcare benefits by virtue of the extra-contractual statements:

Given the lack of evidence of unalterable healthcare coverage after the expiration of the CBAs or that such coverage was changed during the term of the CBAs, defendant could not have breached the CBAs by implementing changes after the expiration. Moreover, defendant's ability to alter retiree healthcare coverage after expiration of the CBAs defeats plaintiff's substantial equivalence argument. 4

Therefore, retirees have lifetime healthcare benefits but defendant may reasonably modify the scope and level of benefits from those that existed when the retirees retired.

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4 While not relevant to this determination, defendant correctly notes "substantial equivalence" was limited to hospital-medical coverage provided during the terms of the CBAs. The phrase was not included in or otherwise made applicable to prescription drug coverage and, in any event, does not purport to apply beyond the expiration of each CBA. [Opinion, p 11]

Plaintiffs appealed by right from this decision, and the County cross appealed. The County submitted that the trial court properly determined that there was no genuine issue of material fact as to a breach of contract, but that the court clearly erred in holding that the County was obligated to provide lifetime benefits, subject to "reasonable" modifications, by virtue of extra-contractual statements by County representatives.

### **Court of Appeals' Opinion**

On April 18, 2017, the Court of Appeals issued a published opinion holding that, under Macomb County's collective bargaining agreements covering the periods from 2000 to 2010, "retiree healthcare benefits are vested." (Slip opinion, p 5) The Court so concluded because (1) the CBAs were "silent" on the issue of whether the healthcare benefits vested

(they “do not expressly state whether the benefits were promised indefinitely or only for the duration of the CBA”), (2) other contract language creates a “latent ambiguity” as to vesting because events triggering the modification of retiree healthcare benefits, such as death of an employee or coverage through another employer, can occur “far beyond the three-year term of the CBAs,” and (3) extrinsic evidence of a bond proposal and statements by the County Executive in 2014, and by a human resources representative, establish an intent in the 2000-2010 CBAs that the healthcare benefits described therein were vested. (Slip opinion, pp 5-6)

The Court further held that the trial court erred in ruling that the County had a right to modify vested healthcare benefits, unilaterally without plaintiffs’ consent. (Slip opinion, p 6)

The Court of Appeals then declared that the trial court had erred in granting defendant’s motion for summary disposition and summarily directed that the trial court enter an order granting plaintiffs motion for summary disposition and for a permanent injunction:

The trial court erred by granting summary disposition in favor of defendant, and summary disposition in favor of plaintiffs was appropriate. Accordingly, we remand this case to the trial court for entry of an order granting summary disposition in favor of plaintiffs and granting plaintiffs’ motion for a permanent injunction in conformance with this opinion.

Affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction. [Slip opinion, p 6]

The County filed a motion for reconsideration, seeking clarification that the grant and denial of summary disposition ordered by the Court of Appeals was solely with respect to the issues it had actually expressly decided, being that (1) there is vesting of the retiree healthcare benefits described in the CBAs, and (2) unilateral modification of the benefits described therein is not permissible. Defendant asked the Court of Appeals to clarify that it had not decided, and was not ordering summary disposition for plaintiffs or against defendant on other issues raised by the parties’ cross motions for summary disposition, that were not addressed by the Court’s opinion. Unaddressed issues included whether the changes in benefits in 2009

and 2010 by the County actually violated any provision of the CBAs regarding the benefits to which the retirees were entitled. Defendant requested that the Court on reconsideration either address these issues, or clarify that they remain open to be addressed by the trial court on remand. The motion for reconsideration was denied by order of May 30, 2017. (Appeal exhibit B)

Macomb County now seeks leave to appeal from, or peremptory reversal, of the Court of Appeals opinion and judgment.

## STANDARD OF REVIEW

A decision on a motion for summary disposition is reviewed de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). When the moving party can show either that an essential element of the nonmoving party's case is missing, or that the nonmoving party's evidence is insufficient to establish an element of its claim, summary disposition for the absence of a genuine issue of material fact under MCR 2.116(C)(10) is properly granted. *Lowrey v LMPS & LMPJ, Inc*, 500 Mich 1, 7-8; 890 NW2d 344 (2016), *Quinto v Cross & Peters Co*, 451 Mich 358, 362; 547 NW2d 314 (1996). Questions of law are reviewed de novo. *Arbuckle v GM LLC*, 499 Mich 521, 531-532; 885 NW2d 232 (2016). Interpretation of a collective-bargaining agreement, like interpretation of any other contract, is also a question of law subject to review de novo. *Id.*

## ARGUMENT

### **I      The Court Of Appeals Clearly Erred In Holding That Retiree Healthcare Benefits Under Macomb County Collective Bargaining Agreements Are Vested, And Unalterable For The Retirees' Lifetimes, Except With The Retirees' Consent, Where The Agreements Are Silent, And Unambiguous, As To Vesting; Resort To Extrinsic Evidence To Find Vesting Is Thus Improper.**

The Court of Appeals in its published opinion has clearly erred in holding that where a collective bargaining agreement is silent as to vesting of retiree health care benefits, ambiguity allowing resort to extrinsic evidence may be found in common CBA provisions setting forth events that will modify a retirees' benefits during the contract period. This determination is, the County submits, directly in violation of fundamental cannons of contract interpretation, and the declaration of Michigan's appellate courts, in agreement with the US Supreme Court, in *M&G Polymers USA, LLC v Tackett*, 574 US\_\_\_; 135 S Ct 926; 190 L Ed 2d 809 (2015), that vesting of retiree healthcare benefits may not be inferred from the silence of a collective bargaining agreement.

This issue has significant public interest, MCR 7.305(B)(2), involves legal principles of major significance to the state's jurisprudence with respect to interpretation of collective bargaining agreements on the critical question of vesting, MCR 7.305(B)(3), and involves a decision of the Court of Appeals that is clearly erroneous and will cause material injustice, MCR 7.305(B)(5)(a).

**A. Under Michigan Contract Principles Applicable To CBAs, Vesting Of Retiree Benefits May Not Be Inferred From Contractual Silence Regarding Vesting.**

**(1) General Contract Principles, Applicable To CBAs.**

“A collective bargaining agreement, like any other contract, is the product of informed understanding and mutual assent.” *Harper Woods Retirees Ass'n v City of Harper Woods*, 312 Mich App 500; 879 NW2d 897 (2015), quoting *Port Huron Ed Ass'n v Port Huron Area Sch Dist*, 452 Mich 309, 327; 550 NW2d 228 (1996). When contractual language is unambiguous, courts must interpret and enforce the language as written because it reflects, as a matter of law, the parties' intent. *Harper Woods Retirees Ass'n v City of Harper Woods*, supra. As the Court of Appeals noted here, quoting from *Kyocera Corp v Hemlock Semiconductor, LLC*, 313 Mich App 437, 446; 886 NW2d 445 (2015):

“This Court's main goal in the interpretation of contracts is to honor the intent of the parties. The words used in the contract are the best evidence [of] the parties' intent. When contract language is clear, unambiguous, and has a definite meaning, courts do not have the ability to write a different contract for the parties, or to consider extrinsic testimony to determine the parties' intent.” [(citations and quotation marks omitted).]

Evidence of contract negotiations, or of prior or contemporaneous agreements that contradict or vary the written contract, is not admissible to vary the terms of a contract that is clear and unambiguous. *Schmude Oil Co v Omar Operating Co*, 184 Mich App 574, 580; 458 NW2d 659 (1990). Application and interpretation of a CBA is a question of the law for the court, unless the CBA is ambiguous. See *Butler v Wayne County*, 289 Mich App 664, 671-

672; 798 NW2d 37 (2010).

**(2) Rights Of Retirees Under A CBA Between The Employer And Employee Representatives (The Union).**

In the particular context of the rights of retirees under a collective bargaining agreement, the rights of retired employees are determined by the terms of the particular CBA in effect at the time of the particular employee's retirement. If a retirement right is vested under the terms of the CBA under which the employee retires, it may not be altered in the future without the retiree's consent. "Under established contract principles, vested retirement rights may not be altered without the [retiree]'s consent." *Butler v Wayne Co*, 289 Mich App 664, 672 (2010); *Harper Woods Retirees Ass'n v City of Harper Woods*, *supra*.

However, in order to demonstrate that a benefit conferred in a CBA is deemed vested, a retiree must show that (1) they had a contractual right to the claimed benefit that was to continue after the agreement's expiration, and (2) the right was included in their respective contracts at the time of retirement. *Harper Woods Retirees Ass'n v City of Harper Woods*, *supra*, citing *Butler*, 289 Mich App at 672. Absent explicit contractual language to the contrary, a retiree's contractual rights vest, if at all, at the time of retirement. *Butler v Wayne County*, 289 Mich App 664, 676 (2010). This Court, in applying federal law in *Arbuckle*, *supra*, stated that: "a union may represent and bargain for already-retired employees, but only with respect to nonvested benefits. By contrast, when an employer explicitly obligates itself to provide vested benefits, that promise is rendered forever unalterable without the retiree's consent." *Arbuckle v Gen Motors, LLC*, 499 Mich 521, 539; 885 NW2d 232 (2016).

**(3) When A CBA Is Silent As To The Duration Of Retiree Benefits, A Court May Not Infer That The Parties Intended Those Benefits To Vest For Life.**

Michigan has endorsed the same contract principles to be applied with respect to whether retiree benefits in a collective bargaining agreement vest as those outlined by the

United States Supreme Court in *M&G Polymers USA, LLC v Tackett*, 574 US\_\_\_; 135 S Ct 926; 190 L Ed 2d 809 (2015), whereby the plain language of the contract governs, and there is no presumption of vesting. *Harper Woods Retirees Ass'n v City of Harper Woods, supra*. See also *Arbuckle v GM LLC*, 499 Mich 521, 531-532; 885 NW2d 232 (2016), applying federal substantive law.

In *M&G Polymers*, the United States Supreme Court rejected the Sixth Circuit's long held "*Yard-Man*" (*UAW v Yard-Man, Inc*, 716 F2d 1476 (CA 6, 1983)) position that, in the absence of contrary extrinsic evidence, courts should presume that retiree benefits provided in a CBA are guaranteed for the lifetime of any employee who retires under the CBA.

*M&G Polymers'* application of basic contract principles was recently summarized by this Court in *Arbuckle v Gen Motors, LLC*, 499 Mich 521, 539; 885 NW2d 232 (2016), in the course of rejecting an argument for vesting of retiree benefits under federal substantive law:

In *M&G Polymers*, the United States Supreme Court disapproved prior Sixth Circuit caselaw, which it characterized as "placing a thumb on the scale in favor of vested retiree benefits in all collective-bargaining agreements." Those decisions, the Supreme Court explained, "distort the text of [a collective-bargaining] agreement and conflict with the principle of contract law that the written agreement is presumed to encompass the whole agreement of the parties." Indeed, basic principles of contract interpretation instruct that "courts should not construe ambiguous writings to create lifetime promises" and, absent a contrary intent, that "'contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement.'" For "when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life." [*Arbuckle, supra*, 540, quoting *M&G Polymers*, 135 S Ct at 936-937, footnotes omitted.]

In *Harper Woods Retirees Ass'n v City of Harper Woods*, the Court likewise quoted from *M&G Polymers*: "[W]hen a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life." quoting *M&G Polymers*, at 937.

**B. As The Macomb County CBAs Are Unambiguous As To Their 3 Year Duration And, As Acknowledged By The Court Of Appeals, Are Silent With Respect To Whether Healthcare Benefits Vest, The Court Of Appeals Should Have Enforced The Contracts As Written, And Should Not Have Turned To Extrinsic Evidence To Find Vesting.**

The Court of Appeals acknowledged that the plain language of the collective bargaining agreements is silent as to, and does not provide for vested lifetime benefits or unalterable benefits, to continue after the CBAs' expiration.

These CBAs are silent on the issue whether the healthcare benefits vested. Each exemplar CBA states that defendant will provide fully-paid medical benefits. However, the CBAs do not expressly state whether the benefits were promised indefinitely or only for the duration of the CBA. [*Kendzierski*, slip opinion, p 4]

The Court of Appeals' conclusion as to silence regarding vesting is correct. From 1989 to present, CBAs between the County and its employees were negotiated with multiple unions, with each in effect for a specific 3 year period; all CBAs in effect in a given three year period were substantially the same, for purposes of the issues in this case. It is undisputed that the CBAs all provided that they were in effect for a specific 3 year period, after which they could be terminated or modified. For example, the CBAs in effect from January 1, 2005 through December, 31, 2007, like those before and after, each provided:

Termination or Modification

- A This Agreement shall continue in full force and effect until December 31, 2007.
- B. If either party wishes to terminate or modify this Agreement, said party shall provide written notice to the other party to that effect. Said notice shall be made no later than one hundred twenty (120) days prior to the termination date in Paragraph A, above. If neither party files a notice of termination or modification, or if each party giving notice of termination or modification withdraws said notice prior to the termination date in Paragraph A, above, this Agreement shall continue in full force and effect from year to year thereafter, subject to timely notice of termination or modification by either party in subsequent year(s) of an extended Agreement. [Exhibit 3 to plaintiff's motion for

summary deposition, complete 2005-2007 CBA between Macomb County And AFSCME Local 411, Article 39, Termination or Modification, p 40, excerpts attached as exhibit D]

Under the contract, the retiree benefit provisions only apply to those who are considered an “employee,” during the contract period, and thus covered by the CBA, but who at some point during the contract become eligible for retiree benefits by virtue of retirement and receipt of a pension. (Exemplar policy, MSD exhibit B, pp 19-20, 22) None of the CBAs state that healthcare coverage for retirees was “vested” or “lifetime,” or “unalterable.” None of the CBAs provide a specific period of duration of those health benefits after a retiree becomes eligible for the benefits. The only period of duration referenced in the CBAs is this three year contract period. (*Id.*)

"[W]hen a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life." *Harper Woods Retirees Ass'n v City of Harper Woods*, quoting *M&G Polymers*, at 937.

**C. The Court Of Appeals Clearly Erred In Concluding That Other Language In The CBAs Creates An Ambiguity With Respect To Whether Retiree Healthcare Benefits Are Vested, So As To Allow Resort To Extrinsic Evidence.**

The Court of Appeals concluded that, while the CBAs are silent as to vesting, “other contract language creates a latent ambiguity regarding whether healthcare benefits are vested,” such that resort to extrinsic evidence to determine whether vesting was contractually mandated was appropriate. (Slip opinion, p 4) In finding a “latent” ambiguity, the Court cited three provisions of the CBAs, each of which sets forth events that will trigger modification, suspension or termination of healthcare coverage of a retiree or retiree’s spouse during the contract period.

First, for purposes of clarification and accuracy, defendant would suggest that the “ambiguity” that the Court of Appeals purported to discern here is not properly characterized

as “latent,” as it is based not upon the Court of Appeals examination of extrinsic evidence, but upon the language of the contract itself. See *Shay v Aldrich*, 487 Mich 648, 641; 790 NW2d 629 (2010) (explaining the distinction between latent and patent ambiguities).<sup>1</sup> The ambiguity perceived by the Court of Appeals was based on the contract language itself, and therefore is properly characterized as a “patent,” not “latent,” ambiguity. *Shay, supra*.

The three CBA provisions identified by the Court of Appeals as creating an ambiguity as to vesting beyond the term of the contracts include (1) continuation of spousal coverage upon death of the retiree, (2) termination of coverage if the retiree fails to enroll in Medicare at age 65, and (3) suspension of coverage if the retiree obtains coverage through another employer.

The Court of Appeals reasoned that because these three events triggering a change in coverage can occur after the three year period of the contract, the parties thereby could have intended that coverage will continue beyond the three year duration of the contract, ad infinitum:

For example, the CBAs contain a "survivor" option permitting continuation of a surviving spouse's health care coverage following the death of the retiree. The fact that this provision contemplates that coverage will continue until, and even after, the death of the retiree indicates that the parties intended that the healthcare coverage would last beyond the three-year term of the individual

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<sup>1</sup> A latent ambiguity exists when the language in a contract appears to be clear and intelligible and suggests a single meaning, but other facts shown by extrinsic evidence create the "necessity for interpretation or a choice among two or more possible meanings." *Shay, supra*. In a simple example cited in *Shay*, in *In re Kremlick Estate*, 417 Mich 237; 331 NW2d 228 (1983), a will bequeathed half of an estate to the "Michigan Cancer Society," which was an existing organization that could have received the money from the estate pursuant to the terms of the will. Thus, the language could have been applied without confusion. Nonetheless, the Court permitted extrinsic evidence to show that the grantor actually intended the beneficiary to be the "Michigan Division of the American Cancer Society" instead, explaining that a latent ambiguity can arise "'where the language employed is clear and intelligible and suggests but a single meaning, but some extrinsic fact or extraneous evidence creates' the possibility of more than one meaning." *Id* at 240.

CBAs. In addition, the CBAs provide that the agreement may be terminated if the retiree fails to enroll in Medicare at age 65. This provision again contemplates that the coverage outlasts the three-year period of the CBA given that a retiree may retire years before turning 65. Furthermore, the CBAs provide that healthcare coverage is suspended while the retiree has coverage through another employer, but then states that coverage through the CBA recommences once the coverage through the other employer ends. Once again, this contract provision indicates that the parties contemplated that the retirees will receive healthcare benefits far beyond the three-year term of the CBAs. [Kendzierski, slip opinion, p 4]

The language of the CBAs upon which the Court of Appeals relied does not support logically its conclusion that the CBAs are ambiguous as to vesting and lifetime retiree healthcare benefits. A patent ambiguity is one that clearly appears on the face of the document at issue and "arises from the defective, obscure, or insensible language used." *In re Kremlick Estate*, 417 Mich 237, 240; 331 NW2d 228 (1983) (quotation marks and citation omitted). "[A] contract is ambiguous when two provisions irreconcilably conflict with each other, or when a term is equally susceptible to more than a single meaning." *Holland v Trinity Health Care Corp*, 287 Mich App 524, 527; 791 NW2d 724 (2010) (citation and quotation marks omitted). "If the contract, although inartfully worded or clumsily arranged, fairly admits of but one interpretation, it is not ambiguous." *Holmes v Holmes*, 281 Mich App 575, 594; 760 NW2d 300 (2008) (quotation omitted).

These three contract provisions cited by the Court setting forth events are not unclear, they do not conflict with any other provisions, and in the context of a three year contract they are not equally susceptible to more than a single meaning. The three provisions setting forth events that will affect retiree healthcare benefits within the three year term on the CBAs carry no suggestion that the benefits they would affect will continue beyond the three year duration of the contract.

Each of these events that are stated to trigger changes in retiree healthcare benefits can and do occur to new retirees within the three year term of the applicable CBA, that establishes

their rights as an employee, at the time of retirement. Within that three year contract period, a retiree may die; a retiree may obtain new employment; a retiree may turn 65. That such events affecting benefits under a CBA also can occur after the contract's end cannot possibly mean that the contract must therefore not ever end. The rights set forth for employees who retire during the life of a CBA are governed by that particular CBA and, as held by the trial court, there is no language in the CBAs here providing for unalterable, lifetime, vested healthcare benefits.

Such provisions for termination of healthcare benefits carry no suggestion of duration of healthcare coverage beyond the three year collective bargaining agreement in effect at the time of the employee's retirement. The contracts do not say, as plaintiffs, and the Court of Appeals, wish to construe them, that "the surviving spouse's healthcare continues for the duration of the survivorship pension, i.e., for the surviving spouse's life." There is no such language in the CBAs tying the duration of pensions to the duration of healthcare benefits. See *Gallo v Moen, infra*.

Rather, the contracts here simply provide for termination of spousal coverage by an event that certainly can occur prior to termination of the CBA, i.e., if the "employee," for whom the CBA's promise is negotiated between the union and the County, becomes a benefit-eligible retiree and then dies during the contract period, but has not elected to exercise a retirement option.

The CBAs here by their terms govern benefits of eligible retirees only during the three year contract period, after which the contract, pursuant to the article on termination and modification, can be terminated or modified. While an ambiguity might be created if the CBAs referred to coverage changing events that could only occur after the three year contract period, thus suggesting that the parties intended rights to extend beyond the contract period,

that is not the case with the contractual provision/triggering events cited by the Court of Appeals here.

By the Court of Appeals' logic, any benefit provided by a CBA that will be affected by events that can occur both during the contract period, and after the end of the contract would create an ambiguity as to whether the benefit continues after the contract end date. This defies logic, common sense, and the plain language of the CBAs setting forth the 3 year term of the contract.

**D. The Analysis Of Vesting Of Retiree Benefits Under *M&G Polymers* And Traditional Canons Of Contract Interpretation Set Forth In The Sixth Circuit's Decision In *Gallo v Moen* Is Correct, And Should Be Applied Here.**

The Sixth Circuit Court of Appeals in several decisions since *M&G Polymers* has addressed the vesting of retiree benefits under collective bargaining agreements. Defendant submits that the Court's analysis in *Gallo v Moen Inc*, 813 F3d 265 (CA 6, 2016), *cert den* 137 S Ct 375 (2016), cited with approval in *Arbuckle v Gen Motors, LLC*, 499 Mich 521, 550, n 56, is compelling and should be applied by this Court to this case and collective bargaining agreements under Michigan law. In *Gallo*, the Sixth Circuit Court of Appeals applied *M&G Polymers*, and the same ordinary contract principles applicable under Michigan law, to reject an argument that benefits vested where terms that triggered eligibility for or modification to benefits could all occur within the three year contract period, and there was no language of duration of benefits beyond the contract period.

In *Gallo*, the CBA contained terms stating that healthcare benefits for retirees "will be provided," "will be covered," and would "[c]ontinue." *Id* at 269. These provisions were determined not to be specific enough to override the CBA's general durational clause and, therefore, the healthcare benefits did not vest for life. *Id*. The court held that "absent a longer time limit in the context of a specific provision, the general durational clause supplies a final

phrase to every term in the CBA." *Id.* In making that determination, the court did not look "beyond the contract's four corners" and ruled that, because the contract was unambiguous, the consideration of extrinsic evidence was inappropriate. *Id.* at 274.

The Court in *Gallo v Moen* held that because the CBA there (like the CBAs here) had no express provision for unalterable healthcare benefits for life, and all provisions were in a three year contract (as are the terms at issue here), there was not a lifetime commitment. The Court reasoned:

First and foremost, nothing in this or any of the other CBAs says that Moen committed to provide unalterable healthcare benefits to retirees and their spouses for life. That is what matters, and that is where the plaintiffs fall short. *Tackett* directs us to apply ordinary contract principles and not to tilt the inquiry in favor of vesting—a frame of reference that prompts two questions. What is the contract right that the plaintiffs seek to vindicate? And does the contract contain that right? The plaintiffs claim a right to healthcare benefits for life. But the contracts never make that commitment.

\* \* \*

Second, not only do the CBAs fail to say that Moen committed to provide unalterable healthcare benefits for life to retirees, everything they say about the topic was contained in a three-year agreement. If we do not expect to find "elephants in mouseholes" in construing statutes [citation omitted], we should not expect to find lifetime commitments in time-limited agreements, *Tackett*, 135 S. Ct. at 936. Each of the CBAs made commitments for approximately three-year terms—well short of commitments for life. [*Gallo v Moen, supra*, 269.]

The Court in *Gallo* held, correctly defendant submits, that the general durational clause in the 3 year CBA “supplies a final phrase to every term in the CBA: ‘until this agreement ends.’ See *Id.*; see also *M&G Polymers*, 135 S Ct. at 936. Reading the healthcare provisions in conjunction with the general durational clause gives meaning to the phrases ‘[c]ontinued,’ ‘will be provided,’ ‘will be covered,’ and the like. These terms guarantee benefits until the agreement expires, nothing more.” *Gallo v Moen, supra*, 269.

Likewise, here, not only do the CBAs fail to impose on the County a contractual commitment to provide unalterable healthcare benefits beyond the duration of the CBAs or for life to retirees, but everything that is said is within the confines of a three-year agreement.

The analysis by the Sixth Circuit Court of Appeals in *Gallo v Moen* is compelling.

Following *Gallo*, on April 20, 2017, three panels of the Sixth Circuit issued published decisions following, or purporting to distinguish *Gallo*. In *Cole v Meritor, Inc.*, 855 F3d 695, 702-703 (CA 6, 2017), the Court followed *Gallo*, with analysis that should be equally applicable here:

But the fact that they anticipated, or even hoped, that these benefits would continue does not mean that Meritor is bound to provide these benefits for the life of the retirees.

*Gallo* instead tells us that, although the parties "may have wished that business conditions and stable healthcare costs (hope springs eternal) would permit it to provide similar healthcare benefits to retirees throughout retirement[,] . . . the question is whether the two parties signed a contract to that effect." *Gallo*, 813 F.3d at 269. Meritor and the UAW signed no such contract. To the contrary, the durational clause in Exhibit B to the 2000 CBA is unambiguous in not vesting retiree healthcare benefits for life.

Because the language of the 2000 CBA is unambiguous, "no basis for going beyond the contract's four corners exists." *Id.* at 274. Legally, that is the end of the matter. [*Cole v Meritor, Inc.*, 855 F3d 695, 702-703 (CA 6, 2017)]

The Sixth Circuit is currently in flux as to interpretation of *Gallo*. In *Int'l Union, UAW v Kelsey-Hayes Co*, 854 F3d 862 (CA 6, 2017), the panel distinguished *Gallo*, and held benefits there to be vested, based on extrinsic evidence turned to because of ambiguity created by a different durational clause which, unlike that here, permitted modification only if the parties arranged a conference to negotiate after notice of intent to modify. In *Reese v CNH Indus NV*, 854 F3d 877 (CA 6 2017), the Court held that there was ambiguity in the contract not resolved by the general durational clause, and that there was vesting, but that in accord with prior law of the case, reasonable modifications could be made by the employer. (The Sixth Circuit docket reflects that, as would be expected, motions for rehearing en banc are pending in all three appeals.)

Defendant submits that this Court should grant leave to address the issue that has so

divided the Sixth Circuit and, defendant submits, confused the Court of Appeals in this matter, being whether ambiguity regarding vesting may be inferred from CBAs' silence, in the face of an explicit 3 year durational clause.

**II Alternatively, Even Assuming Arguendo, That The Collective Bargaining Agreements Were Ambiguous With Respect To Whether Retiree Healthcare Benefits Were Vested, The Court Of Appeals Clearly Erred In Holding That, As A Matter Of Law, Extrinsic Evidence Established An Agreement That The Benefits As Described In The CBAs Were Vested And Unalterable Without Consent; At A Minimum A Question Of Fact Remains For The Trier of Fact.**

Even if the CBAs are ambiguous, so as to permit consideration of extrinsic evidence, the extrinsic evidence in the record before the Court of Appeals does not establish, as a matter of law, an agreement by the County that the benefits specified in the CBAs in and before 2010 were vested for life and unalterable. At a minimum, the evidence created an issue of fact as to whether there was vesting, and if so what benefits vested. This issue has significant public interest, MCR 7.305(B)(2), and involves a decision of the Court of Appeals that is clearly erroneous and will cause material injustice, MCR 7.305(B)(5)(a).

This Court has held that interpretation of an ambiguous contract is a question of fact for the jury:

It is well settled that the meaning of an ambiguous contract is a question of fact that must be decided by the jury. *Hewett Grocery Co v Biddle Purchasing Co*, 289 Mich 225, 236; 286 NW 221 (1939). "Where a contract is to be construed by its terms alone, it is the duty of the court to interpret it; but where its meaning is obscure and its construction depends upon other and extrinsic facts in connection with what is written, the question of interpretation should be submitted to the jury, under proper instructions." *O'Connor v March Automatic Irrigation Co*, 242 Mich 204, 210; 218 NW 784 (1928). [*Klapp v United Ins Group Agency, Inc*, 468 Mich 459, 469; 663 NW2d 447 (2003).]

The Court of Appeals here impermissibly acted as finder of fact in declaring that the extrinsic evidence established that the County had agreed in decades of CBAs that retirees were entitled to vested healthcare benefits. In holding that there was contractual agreement to

vested benefits, the Court reasoned:

In determining that the healthcare benefits were lifetime benefits, the trial court examined a 2014 bond funding proposal, accompanied by a letter from the Macomb County Executive. We agree with the trial court that this unrefuted evidence established the intent of the parties to provide lifetime healthcare benefits to retirees. The trial court relied on a sentence in the 2014 bond proposal, which read, "The County provides retiree health benefits to eligible County retirees (and their eligible beneficiaries) for their lifetimes." (Emphasis added.) The proposal acknowledged that the practice of funding retiree healthcare benefits began 20 years earlier. Additionally, the proposal provided, "Historically, Macomb County has offered retiree healthcare to vested employees as part of their benefit package." (Emphasis added.)

We conclude that these statements by defendant establish that the healthcare benefits are vested. The first statement expressly provides that the healthcare benefits last for the life of the retiree and the retiree's eligible beneficiaries. The second statement provides that healthcare benefits are granted to employees with vested rights and states that this has been an historical practice of the county. Importantly, the bond proposal outlines defendant's 20-year history of funding the health benefits, suggesting that defendant took this position during the period in which plaintiffs retired and continued to take the same position during the pendency of this case.<sup>1</sup> Accordingly, plaintiffs presented unrefuted evidence establishing that the retiree healthcare benefits are vested.

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<sup>1</sup> In addition to this dispositive evidence, plaintiffs presented evidence that a human resources representative for defendant informed retirees that the healthcare benefits are lifetime benefits. [*Kendzierski*, slip opinion, 5]

At a minimum, the record established an issue of fact as to whether there was a contractual promise by the County in the decades of CBAs prior to 2010 to provide retiree lifetime healthcare benefits, and if so, what benefits were promised, and whether they were alterable after each three year contract period. First, the bond proposal statements were made 4 years after the expiration of the last CBA at issue by County representatives who were not shown to have any role in negotiating or agreeing to the prior contracts. As such, the trier of fact should be entitled to discount their relevance to negotiations years, or decades earlier. A "contract must be construed so as to effectuate the intent of the parties when it was made; and, to ascertain the intent of the parties, a contract should be construed in the light of the

circumstances existing at the time it was made." *Sobczak v Korwicki*, 347 Mich 242, 249; 79 NW2d 471 (1956).

Further, while the statements reflect the County's intent and desire in 2014 to fund healthcare benefits with the hope that they can be provided to retirees for their lifetime, this is not the same as a concession of a contractual obligation to provide lifetime benefits, or a contractual obligation to provide very specific benefits. The County has every hope and expectation that it will be able to provide its retirees with continued healthcare benefits. But, this is not a matter of binding contract or a contractual obligation. That the County expects that it will continue to provide benefits is not pertinent to the contractual issues here. As cogently reasoned by the Court in *Gallo v Moen*:

The plaintiffs point to extrinsic evidence, such as the fact that Moen continued paying healthcare benefits for five years after the plant closing agreement expired, claiming that this shows the parties' "inten[t]" to create vested and unalterable retiree healthcare benefits. Appellees' Br. 57. Two responses. The first and best way to divine the intent of the parties is from the four corners of their contract and from traditional canons of contract interpretation. That language and these canons offer no evidence of any intent to fix these benefits permanently into the future. Absent ambiguity from this threshold inquiry, no basis for going beyond the contract's four corners exists. See *Witmer v. Acument Global Techs., Inc.*, 694 F.3d 774, 778 (6th Cir. 2012). At any rate, a company does not act inconsistently when (1) it continues paying healthcare benefits to retirees and (2) reserves the right to alter or eliminate those benefits in the future. That a company to its credit hopes to subsidize healthcare benefits for its retirees for as long as possible does not mean it has promised to do so, and above all such action does not mean that it has no right to alter those benefits in the future to account for changes to its healthcare plans for employees or, as here, to account for new federal legislation. [*Gallo v Moen, supra*, 273-274.]

Likewise here, that the County "to its credit hopes to subsidize healthcare benefits for its retirees for as long as possible" and has undertaken responsible fiscal steps to enable it to do so, "does not mean . . . that it has no right to alter those benefits in the future. . . ." *Gallo v Moen, supra*, 274.

Moreover, defendant produced evidence that (1) retiree health care benefits for all

current and past retirees were modified with each 3 year CBA to generally mirror modifications in current employee health care benefits, such that retirees were not “vested” with the particular benefits of the particular CBA under which they retired, and (2) benefits were modified without retiree assent during various contract periods. As noted in the Statement of Facts, prior to the benefits changes in 2009 and 2010 challenged by plaintiffs in this matter, the County had modified retiree healthcare benefits on many occasions. Examples of historical changes to retiree healthcare benefits are as follows:

- In 1988, retirees covered by Blue Cross Blue Shield (“BC/BS”) could now select PPO coverage
- In 1989, defendant’s Board of Commissioners advised it would offer fully paid healthcare to all county retirees and/or their spouses regardless of the year they retired.
- In 1990, retirees were offered dental (with an \$800 maximum) and optical at the same levels of coverage as employees with a 25% premium sharing for retiree and 100% premium sharing for spouse.
- In 1996, non-Medicare eligible retirees were offered BC/BS PPO
- In 2002, the retirees enrolled in PPO and Traditional were given the option to purchase hearing coverage.
- In 2003, a PPO was made available to Medicare eligible retirees and prescription co-pays for all non-HMO retirees increased from \$2 to \$5.
- In 2005, Medicare-eligible were offered BC/BS PPO
- In 2006, retirees using mail order prescriptions had their co-pays increase from \$2 to \$5. [Defendant’s MSD exhibits B, C, M, Human Resource’s Bulletins re changes in benefits]

No litigation or challenge ensued with respect to these changes, and the retirees have admitted that they never complained of these changes. (See e.g. defendant’s MSD exhibit D, Bertolli dep, p 30; defendant’s MSD exhibit E, Cowan dep, pp 23-25, 54)

While the Court of Appeals also noted that a human resources representative for the

County informed retirees that healthcare benefits are lifetime benefits, this was based only on to a single class member's deposition testimony that directly conflicts with the testimony of other class members. (Defendant's MSD Ex D, Barker dep, pp 41-44) Further, John Barker only *believed* that one representative told him that his benefits would remain the same, and he was unable to produce anything in writing to confirm this. (Barker dep, pp 22-23)

Further, the 2014 proposal cited by the Court of Appeals trial merely states: "Historically, Macomb County has offered retiree healthcare to *vested employees* as part of their benefit package." (emphasis added). It notably lacks the language "vested healthcare."

Therefore, even if the CBAs were ambiguous, the extrinsic evidence created at a minimum, an issue of fact as to what benefits were promised, and whether they were alterable after each three year contract period.

**III      Regardless Of Whether Retiree Healthcare Benefits Vested, The Court Of Appeals Erred In Ordering That Plaintiffs' Motion For Summary Disposition Be Granted, Where Plaintiffs Failed To Demonstrate A Genuine Issue Of Material Fact As To A Breach Of The CBAs By Virtue Of The Changes To Healthcare Insurance (Except As To Prescription Drug Coverage For Non-Medicare Eligible Retirees), Implemented By The County In 2009 And 2010.**

Although the Court of Appeals directed that plaintiffs' motion for summary disposition be granted, and defendant's motion be denied, neither the Court of Appeals nor the trial court addressed the issue of whether, regardless of if healthcare benefits "vested," the changes in 2009 and 2010 actually breach the contractual rights agreed to in the 2008-2010 CBAs. Plaintiffs thus are not entitled to summary disposition as requested--that the County breached the CBAs and that plaintiffs are entitled to a return to the status quo before the 2009 and 2010 plan changes--because changes to the health care plans not were inconsistent with the benefits granted by the CBAs (except with respect to prescription drug coverage for non-Medicare eligible retirees). Rather, defendant is entitled to summary disposition, or in the alternative and at a minimum, these are questions of fact as to breach of contract, for the trier

of fact that must be resolved.

This issue has significant public interest, MCR 7.305(B)(2), given the number in the class, and involves a decision of the Court of Appeals that is clearly erroneous and will cause material injustice, MCR 7.305(B)(5)(a).

**A. Relevant 2008 – 2010 CBA Provisions Regarding Retirees, And Medicare Eligible Retirees.**

The 2008 – 2010 CBAs contained the following provisions regarding hospital-medical insurance benefits and drug coverages relevant to active employees, and non-Medicare eligible retirees, Medicare-eligible retirees, as well as the definition of the term used therein with respect to employees and non-Medicare eligible retirees, “substantial equivalence.”

ARTICLE 19

INSURANCE BENEFITS

A. Life Insurance \* \* \*

B. Hospital-Medical Insurance:

1. Active Employees \* \* \*The Employer shall provide fully paid Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence and Health Maintenance (HMO) coverage or its substantial equivalence to all regular employees and their eligible family members, including prescription drug coverage as outlined in Appendix D.

\* \* \*

2. Retirees: The Employer will provide fully paid **Blue Cross/Blue Shield Preferred Provider Organization (PPO)** coverage **or its substantial equivalence** to the employee and the employee’s spouse, after eight (8) years of service with the employer, for the Employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees’ Retirement Ordinance [pension plan], **based upon the following conditions and provisions:** \* \* \*

- a. \* \* \*

b. \* \* \*

Effective January 1, 2006, an eligible retiree, and the person who is said retiree's spouse at the time of retirement, covered by a Blue Cross/Blue Shield healthcare plan will be enrolled in the Preferred Rx Managed Prescription drug program. Coverage is as follows:

(1) \* \*\*

(2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.

(3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$5.00.

(4) \* \* \*

c. [Medicare eligible retirees] Retired employees and/or their current spouse, **shall apply and participate in the Medicare Program, if eligible**, at their expense as required by the Federal Insurance Contribution Act, a party of the Social Security Program, **at which time the Employer's obligation shall be only to provide "over 65 supplemental" hospital-medical benefit coverage.** \* \* \*

\* \* \*

H. Determination of substantial equivalency, as expressed herein, will be subject to review and agreement by the Parties to this Agreement, prior to implementation of the same. [Emphasis added, Exemplar policy, appeal exhibit E]

The CBAs also provided that the Employer will provide an HMO option, provided that the premium does not exceed the cost of present insurance. (Exemplar policy, MSD Exhibit B, Article 19, Section C, subsection 3, p 21, appeal exhibit E)

**B. There Was No Breach As To Medicare-Eligible Retirees With Regard To The Changes In Hospital-Medical Insurance Provider And Plan, Or Prescription Drug Coverage, As They Were Entitled Under The CBAs "Only" To "Over 65 Supplemental" Hospital-Medical Benefit Coverage, Which Was Provided.**

By virtue of Article 19, paragraph B 2(c) in the exemplar policy quoted above, under the 2008 – 2010 CBAs (as well as prior CBAs), the County employer's "only" obligation with respect to Medicare-eligible retirees was to provide "'over 65 supplemental' hospital-medical

benefit coverage.” That is, the introductory paragraph regarding “Hospital-Medical Insurance,” applicable to retirees, provides for “Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage,” “based upon the following conditions and provisions. . .”. (Exemplar policy, paragraph B 2) The coverage for those retirees who are Medicare eligible is then sharply limited in paragraph B 2(c):

Retired employees and/or their current spouse, upon reaching age 65, shall apply if eligible, and participate in the Medicare Program at their expense as required by the Federal Insurance Contribution Act, a part of the Social Security Program, **at which time the Employer’s obligation shall be only to provide “over 65 supplemental” hospital-medical benefit coverage.** [Emphasis added, exemplar policy, appeal exhibit E, p 19]

Thus, under the contract provisions specifically applicable to Medicare-eligible retirees, the employer’s obligation “shall be only to provide ‘over 65 supplemental’ hospital-medical benefit coverage.” (*Id*, emphasis added) There is no provision in the CBAs, applicable to Medicare-eligible retirees, that addresses either the type of coverage or carrier for such over 65 supplemental hospital-medical benefit coverage, or that addresses prescription drug coverage.

In light of the CBA contract provision specifically limiting the County’s obligations to Medicare-eligible retirees, there could have been no breach by virtue of the changes implemented by the County in 2010 with respect to those retirees. In 2010, Medicare-eligible retirees received a supplemental health plan from United American Insurance Company (administered by AmWins). (Defendant’s MSD exhibit I, Gelman 7/9/15 affidavit affidavit) The prior options for Medicare-eligible retirees of Health Alliance Plan, Blue Care Network, BCBS PPO and BCBS Traditional were eliminated in 2010. This change was completely consistent with the language of the CBAs. It is undisputed that the County in 2009 and 2010 continued to provide Medicare-eligible retirees with “over 65 supplemental” hospital-medical benefit coverage, from United American Insurance Company (administered by AmWins). No further obligation was imposed by the CBAs with respect to the scope or nature of coverage

for Medicare-eligible retirees.

While plaintiffs claimed that the Medicare-eligible retirees were “forced” from the Blue Cross Blue Shield plans, from which they had previously had an option to choose, to the United American (AmWins) policy, this was consistent with, and not a breach of, the CBAs. The United American policy unquestionably was a Medicare supplement plan, that provided “over 65 supplemental” hospital-medical benefit coverage. This was all that was required by the CBAs. See Article 19, paragraph B 2 (c) of the exemplar policy, quoted above. The County had no obligation to provide Medicaid eligible retirees with any particular supplemental coverage, or coverage from any particular provider, or prescription drug coverage of any nature whatsoever.

As the County met its only obligation under the CBAs with respect to healthcare benefits for Medicare-eligible retirees--providing “over 65 supplemental” hospital-medical benefit coverage--summary disposition was properly granted as to these retirees. As to this issue, the County’s motion for summary disposition should have been granted, and plaintiffs’ motion for summary disposition, should have been denied.

**C. There Was No Breach As To The Non-Medicare Eligible Retirees With Regard To The Change In Healthcare Plans, As They Were Entitled Under The CBAs Only To “Blue Cross/Blue Shield Preferred Provider Organization (PPO) Coverage,” And An HMO Option, Both Of Which Were Provided; Further Coverage Remained “Fully Paid.”**

With respect to non-Medicare eligible retirees and their spouses, the unambiguous language of the 2008–2010 CBAs provided only that the Employer will provide “fully paid Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence”:

Retirees: The Employer will provide fully paid **Blue Cross/Blue Shield Preferred Provider Organization (PPO)** coverage or its substantial equivalence to [eligible retirees]\* \* \* **based upon the following conditions and provisions:** \* \* [Emphasis added, Exemplar policy, appeal exhibit E, p 19]

In 2010, non-Medicare eligible retirees were transitioned from Blue Cross Traditional, and Community Blue PPO 5, to Blue Cross/Blue Shield of Michigan PPO 6, and from Health Alliance Plan HMO to Blue Care Network HMO. (Coverages for these new plans were outlined in Appendix D to the CBAs) The Blue Cross Traditional, Community Blue PPO 5, and Health Alliance Plan HMO were eliminated.

With the 2010 changes, the employer did continue to provide that coverage specified in the 2008-2010 CBAs--“Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage,” and an HMO option, to non-Medicare eligible retirees. This was all that was required by the CBAs. While the precise type of “Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage” changed, the type of “Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage,” PPO 5 or PPO 6, was not a term covered or specified by the CBAs.

Thus, with the 2010 changes, the County continued to provide precisely the only coverage specified by the CBAs--Blue Cross/Blue Shield PPO coverage, being Blue Cross/Blue Shield of Michigan PPO 6, and an HMO option, being Health Alliance Plan. Nothing in the CBAs specified the type of “Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage,” or prohibited the County from switching from one type of “Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage,” to another.

Plaintiffs’ counsel has to date below and on appeal asserted, without supporting evidence or affidavit, that the implementation of, or change in, various deductibles, copays or co-insurance in 2010 resulted in a breach of the CBAs’ requirement that the employer provide “fully paid” healthcare insurance coverage. However, the evidence in the record conclusively negates this claim by counsel, and demonstrates that coverage remained “fully paid,” after the 2010 changes.

First, defendant, by expert affidavit submitted in the trial court, demonstrated that the term “fully paid benefits,” as used in CBAs, is a term of art in the insurance industry. The term means only that that the employer pays the insurance premiums. (7/30/15 affidavit of Laurence Gelman, ¶¶4, 5, exhibit A to defendant’s response to plaintiffs’ motion for summary disposition) As set forth in this (unrebutted) affidavit of defendant’s expert in healthcare benefits, Laurence Gelman, the term “fully paid benefits,” does not refer to the payment of deductibles, co-insurance or co-pays. “Thus, employees may still have to pay all of those costs [deductibles, co-insurance and/or co-pays] when their healthcare benefits are considered to be ‘fully paid.’” (7/30/15 affidavit of Laurence Gelman, ¶¶4, 5, exhibit A to defendant’s response to plaintiffs’ motion for summary disposition)

It is undisputed that although retirees had various deductibles and/or co-pays, the premiums for the plans offered to retirees were fully paid by the employer County. Thus, the healthcare benefits were “fully paid.” (*Id.*) Plaintiffs came forth with no evidence to dispute this fact, or create a genuine issue of material fact as to the meaning of the term “fully paid.” This was despite the fact that plaintiffs on their witness list listed many insurance industry representatives, and Suzanne Parajpe, PhD, as a Healthcare Economist Expert. (See plaintiffs’ third witness list, dated 2/8/13)

Second, the fact that the promise to provide “fully paid” coverage in the CBAs is not inconsistent with or violated by the imposition of deductibles, copays or coinsurance is also evident from the very terms of the 2008 – 2010 CBAs themselves. Specifically, the CBAs provided that active employees were to be provided “fully paid Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence \* \* \* as outlined in Appendix D.” Appendix D, in outlining the “fully paid” coverage to provide by the Community Blue PPO Plan 6, specifically included deductibles and copays. (Exemplar

2008 – 2010 policy) Thus, “fully paid” cannot mean that there are no deductibles or copays, because they were included in the CBAs, along with the requirement of “fully paid” coverage.

Accordingly, as the County provided “fully paid Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage” for non-Medicare eligible retirees, the terms of the 2008-2010 CBAs were met precisely. There was no need to consider substantial equivalence, and there was no breach. As to this issue, the County’s motion for summary disposition should have been granted, and plaintiffs’ motion for summary disposition, should have been denied.

### **RELIEF REQUESTED**

The County has every hope and expectation that it will be able to provide its retirees with continued healthcare benefits. But, this is not a matter of binding contract or a contractual obligation. That the County expects that it will continue to provide benefits is not pertinent to the contractual issues here. As cogently reasoned by the Court in *Gallo v Moen*:

The plaintiffs point to extrinsic evidence, such as the fact that Moen continued paying healthcare benefits for five years after the plant closing agreement expired, claiming that this shows the parties' "inten[t]" to create vested and unalterable retiree healthcare benefits. Appellees' Br. 57. Two responses. The first and best way to divine the intent of the parties is from the four corners of their contract and from traditional canons of contract interpretation. That language and these canons offer no evidence of any intent to fix these benefits permanently into the future. Absent ambiguity from this threshold inquiry, no basis for going beyond the contract's four corners exists. See *Witmer v. Acument Global Techs., Inc.*, 694 F.3d 774, 778 (6th Cir. 2012). At any rate, a company does not act inconsistently when (1) it continues paying healthcare benefits to retirees and (2) reserves the right to alter or eliminate those benefits in the future. That a company to its credit hopes to subsidize healthcare benefits for its retirees for as long as possible does not mean it has promised to do so, and above all such action does not mean that it has no right to alter those benefits in the future to account for changes to its healthcare plans for employees or, as here, to account for new federal legislation. [*Gallo v Moen*, *supra*, 273-274.]

Likewise here, that the County “to its credit hopes to subsidize healthcare benefits for its retirees for as long as possible” and has undertaken responsible fiscal steps to enable it to do so, “does not mean . . .that it has no right to alter those benefits in the future. . .” *Gallo v Moen, supra*, 274.

WHEREFORE, defendant-appellant County of Macomb respectfully requests that this Honorable Court grant leave to appeal or peremptorily reverse the Court of Appeals and hold that that plaintiffs and other retirees do not have a vested right to lifetime, unalterable healthcare benefits, and affirm the trial court’s judgment dismissing this class action breach of contract lawsuit.

Alternatively, defendant asks that this Court hold that summary disposition should not be granted to plaintiffs, as there remains an issue of fact as to whether and what retiree benefits vested, and that summary disposition should be granted to the County as set forth in Argument III, as the changes in benefits in 2009 and 2010 did not violate the terms of the collective bargaining agreements.

KITCH DRUTCHAS WAGNER  
VALITUTTI & SHERBROOK

By: /s/ Susan Healy Zitterman  
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KAREN B. BERKERY (P38698)  
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County of Macomb  
One Woodward Avenue, Suite 2400  
Detroit, MI 48226  
(313) 965-7905

Dated: July 10, 2017

STATE OF MICHIGAN  
IN THE COURT SUPREME COURT

RITA KENDZIERSKI, BONNIE HAINES,  
GREG DENNIS, LOUISE BERTOLINI,  
JOHN BARKER, JAMES COWAN,  
VINCENT POWIERSKI, ROBERT STANLEY,  
ALAN MOROSCHAN, and GAER GUERBER,  
on behalf of themselves and those who are  
similarly situated,

Supreme Court No.

Court of Appeals  
No. 329576

Macomb County Circuit Court  
No. 10-001380-CK

Plaintiffs-Appellees

v

COUNTY OF MACOMB,

Defendant-Appellant.

/

**NOTICE OF FILING SUPREME COURT APPLICATION**

Jerome W. Zimmer Jr  
Court of Appeals Chief Clerk  
Michigan Court of Appeals  
Cadillac Place  
3020 West Grand Blvd. Suite 14-300  
Detroit, MI 48202

Clerk of the Court  
Macomb County Circuit Court  
Appeals Division  
40 N. Main Street  
Mt. Clemens, MI 48043-5656

PLEASE BE ADVISED that an Application for Leave to Appeal by defendant-appellant County of Macomb has been filed with the Michigan Supreme Court.

KITCH DRUTCHAS WAGNER  
VALITUTTI & SHERBROOK

By: /s/ Susan Healy Zitterman  
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Dated: July 10, 2017

STATE OF MICHIGAN  
IN THE COURT SUPREME COURT

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ALAN MOROSCHAN, and GAER GUERBER,  
on behalf of themselves and those who are  
similarly situated,

Supreme Court No.

Court of Appeals  
No. 329576

Macomb County Circuit Court  
No. 10-001380-CK

Plaintiffs-Appellees

v

COUNTY OF MACOMB,

Defendant-Appellant.

**CERTIFICATE OF SERVICE**

I hereby certify that on July 10, 2017, I electronically filed the foregoing  
**APPLICATION FOR LEAVE TO APPEAL AND BY DEFENDANT-APPELLANT  
COUNTY OF MACOMB, NOTICE OF FILING SUPREME COURT APPLICATION,  
EXHIBITS and CERTIFICATE OF SERVICE** with the Clerk of the Court using the ECF  
system which will send notification of same to the attorneys of record:

CHRISTOPHER P. LEGGHIO (P27378)  
Legghio & Israel, P.C.  
Attorney for Plaintiff-Appellee  
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/s/ Doris G. Jones  
DORIS G. JONES  
Secretary to Susan Healy Zitterman

DET02:2400011.1

STATE OF MICHIGAN  
IN THE COURT SUPREME COURT

RITA KENDZIERSKI, BONNIE HAINES,  
GREG DENNIS, LOUISE BERTOLINI,  
JOHN BARKER, JAMES COWAN,  
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Macomb County Circuit Court  
No. 10-001380-CK

Plaintiffs-Appellees

v

COUNTY OF MACOMB,

Defendant-Appellant.

**EXHIBITS TO APPLICATION FOR LEAVE TO APPEAL AND BY DEFENDANT-  
APPELLANT COUNTY OF MACOMB**

KITCH DRUTCHAS WAGNER  
VALITUTTI & SHERBROOK

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**INDEX OF EXHIBITS**

**EXHIBIT A Court of Appeals Opinion**

**EXHIBIT B Order Denying Motion for Reconsideration**

**EXHIBIT C Macomb County Circuit Court Opinion and Order**

**EXHIBIT D Excerpts of Agreement between County of Macomb and American Federation of State, County and Municipal Employees Local 411 – January 1, 2005 through December 31, 2007**

**EXHIBIT E Excerpts of Agreement between County of Macomb and American Federation of State, County and Municipal Employees Local 411 – January 1, 2008 through December 31, 2010**

**EXHIBIT A**

STATE OF MICHIGAN  
COURT OF APPEALS

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RITA KENDZIERSKI, BONNIE HAINES, GREG  
DENNIS, LOUISE BERTOLINI, JOHN  
BARKER, JAMES COWAN, VINCENT  
POWIERSKI, ROBERT STANLEY, ALAN  
MOROSCHAN, and GAER GUERBER, on  
Behalf of Themselves and All Others Similarly  
Situating,

FOR PUBLICATION  
April 18, 2017  
9:00 a.m.

Plaintiffs-Appellants/Cross-  
Appellees,

v

MACOMB COUNTY,

No. 329576  
Macomb Circuit Court  
LC No. 2010-001380-CK

Defendant-Appellee/Cross-  
Appellant.

---

Before: FORT HOOD, P.J., and JANSEN and HOEKSTRA, JJ.

JANSEN, J.

In this class action, plaintiffs, acting as class representatives, appeal as of right the trial court's opinion and order denying their motion for summary disposition and request for a permanent injunction with regard to defendant's unilateral modification of retiree healthcare benefits. On cross-appeal, defendant challenges the same order, asserting that the trial court's finding that plaintiffs' healthcare retirement benefits were vested or comprised an entitlement to lifetime benefits constituted error. We affirm in part, reverse in part, and remand for further proceedings consistent with this opinion.

This case presents the issue whether defendant was permitted to make unilateral changes to retiree healthcare benefits outlined in several collective bargaining agreements (CBAs). Plaintiffs represent a class of retirees covered under various CBAs with defendant. The parties dispute (1) whether plaintiffs have a vested right to lifetime healthcare benefits, and (2) if so, whether defendant was permitted to make unilateral changes to the healthcare benefits. The trial court concluded that plaintiffs have a vested right to lifetime healthcare benefits. However, the court then concluded that defendant could reasonably modify the scope and level of the benefits. The court, therefore, granted summary disposition in favor of defendant.

## I. STANDARD OF REVIEW

Plaintiffs moved for summary disposition pursuant to MCR 2.116(C)(10). Defendant moved for summary disposition under MCR 2.116(C)(7), (8), and (10). We review de novo a trial court's ruling on a motion for summary disposition. *Stephens v Worden Ins Agency, LLC*, 307 Mich App 220, 227; 859 NW2d 723 (2014). Because the trial court clearly relied on documents outside of the pleadings, including the CBAs, deposition testimony, and other documentation submitted by the parties, we conclude that summary disposition was granted to defendant under MCR 2.116(C)(10). See *Cuddington v United Health Servs, Inc*, 298 Mich App 264, 270; 826 NW2d 519 (2012) ("The trial court did not indicate whether it granted defendant's motion pursuant to MCR 2.116(C)(8) or (10); however, because the trial court considered documentary evidence beyond the pleadings, we construe the motion as having been granted pursuant to MCR 2.116(C)(10).").

A motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. In reviewing a grant of summary disposition under MCR 2.116(C)(10), this Court considers the pleadings, admissions, and other evidence submitted by the parties in the light most favorable to the nonmoving party. Summary disposition is appropriate if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. [*Williams v Enjo Transp Solutions*, 307 Mich App 182, 185; 858 NW2d 530 (2014) (citations omitted).]

In addition, "A written contract's interpretation is also reviewed de novo." *Reicher v SET Enterprises, Inc*, 283 Mich App 657, 664; 770 NW2d 902 (2009).

We enforce contracts according to their terms, as a corollary to the parties['] liberty to enter into a contract. We examine contractual language and give the words their plain and ordinary meanings. An unambiguous contractual provision reflects the parties['] intent as a matter of law, and [i]f the language of the contract is unambiguous, we construe and enforce the contract as written. Courts may not create ambiguity when contract language is clear. Rather, this Court must honor the parties' contract, and not rewrite it. [*Id.* at 664-665 (citations and quotation marks omitted; third alteration in original).]

## II. VESTED BENEFITS

Defendant argues that the trial court improperly concluded that plaintiffs are entitled to lifetime healthcare benefits. We disagree.

To determine whether plaintiffs' right to healthcare benefits had vested, we first examine the CBA language at issue in the context of accepted principles of contract interpretation. "Under established contract principles, vested retirement rights may not be altered without the [retiree]'s consent." *Harper Woods Retirees Ass'n v Harper Woods*, 312 Mich App 500, 511; 879 NW2d 897 (2015) (citation and quotation marks omitted; alteration in original). Our Supreme Court in *Arbuckle v Gen Motors, LLC*, 499 Mich 521, 539; 885 NW2d 232 (2016), recently observed that "a union may represent and bargain for already-retired employees, but

only with respect to *nonvested* benefits. By contrast, when an employer explicitly obligates itself to provide vested benefits, that promise is rendered forever unalterable without the retiree's consent."

To determine whether the right to the healthcare benefits vested, a plaintiff must establish that "(1) he or she had a contractual right to the claimed benefit that was to continue after the agreement's expiration, and (2) the right was included in his or her respective contract at the time of retirement." *Harper Woods*, 312 Mich App at 511. Before the United States Supreme Court issued its opinion in *M & G Polymers USA, LLC v Tackett*, 574 US \_\_\_\_; 135 S Ct 926; 190 L Ed 2d 809 (2015), a presumption existed in the United States Court of Appeals for the Sixth Circuit that retiree benefits outlined in a CBA are vested lifetime benefits. *Harper Woods Retirees Ass'n*, 312 Mich App at 511-512. In *Tackett*, the United States Supreme Court concluded that this presumption was inconsistent with the traditional rules of contract law. *Tackett*, 574 US at \_\_\_\_; 135 S Ct at 937; 190 L Ed 2d at 821. The Court indicated that ordinarily, a contractual obligation ceases when the CBA terminates. *Id.* at \_\_\_\_; 135 S Ct at 937; 190 L Ed 2d at 820. "[W]hen a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life." *Id.* at \_\_\_\_; 135 S Ct at 937; 190 L Ed 2d at 820. However, the Court clarified that its holding did not preclude a conclusion that the parties intended for the lifetime benefits to vest, so long as ordinary contract principles were used to reach that conclusion. *Id.* at \_\_\_\_; 135 S Ct at 937; 190 L Ed 2d at 820.

Our Supreme Court expanded upon this idea in *Arbuckle*:

Indeed, basic principles of contract interpretation instruct that courts should not construe ambiguous writings to create lifetime promises and, absent a contrary intent, that contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement. For when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life. [*Arbuckle*, 499 Mich at 540 (citations and quotation marks omitted).]

Accordingly, we examine the traditional rules of contract interpretation to determine whether plaintiffs had the right to lifetime healthcare benefits. As explained in *Arbuckle*:

Interpretation of a collective-bargaining agreement, like interpretation of any other contract, is . . . a question of law also subject to review de novo. A reviewing court interprets a collective-bargaining agreement according to ordinary principles of contract law, at least when those principles are not inconsistent with federal labor policy. [*Id.* at 531-532 (citations and quotation marks omitted).]

This Court has recently recognized:

This Court's main goal in the interpretation of contracts is to honor the intent of the parties. The words used in the contract are the best evidence [of] the parties' intent. When contract language is clear, unambiguous, and has a definite meaning, courts do not have the ability to write a different contract for the parties,

or to consider extrinsic testimony to determine the parties' intent. [*Kyocera Corp v Hemlock Semiconductor, LLC*, 313 Mich App 437, 446; 886 NW2d 445 (2015) (citations and quotation marks omitted).]

However, when a contract contains a latent ambiguity, then extrinsic evidence may be admitted to establish the meaning of the contract. *Shay v Aldrich*, 487 Mich 648, 667; 790 NW2d 629 (2010). Our Supreme Court has described a latent ambiguity as follows:

A latent ambiguity . . . is one that does not readily appear in the language of a document, but instead arises from a collateral matter when the document's terms are applied or executed. Because the detection of a latent ambiguity requires a consideration of factors outside the instrument itself, extrinsic evidence is obviously admissible to prove the existence of the ambiguity, as well as to resolve any ambiguity proven to exist. [*Id.* at 668 (citation and quotation marks omitted).]

Our Supreme Court has further explained that

[a] latent ambiguity exists when the language in a contract appears to be clear and intelligible and suggests a single meaning, but other facts create the necessity for interpretation or a choice among two or more possible meanings. To verify the existence of a latent ambiguity, a court must examine the extrinsic evidence presented and determine if in fact that evidence supports an argument that the contract language at issue, under the circumstances of its formation, is susceptible to more than one interpretation. Then, if a latent ambiguity is found to exist, a court must examine the extrinsic evidence again to ascertain the meaning of the contract language at issue. [*Id.* (citations and quotation marks omitted).]

We disagree with the trial court's conclusion that the CBAs are unambiguous. Due to the plethora of CBAs existing at various times with different unions, following the method used by the trial court, we have selected exemplars to reflect the language at issue for the periods encompassing: (a) 2000 to 2004, (b) 2005 to 2007, and (c) 2008 to 2010. These CBAs are silent on the issue whether the healthcare benefits vested. Each exemplar CBA states that defendant will provide fully-paid medical benefits. However, the CBAs do not expressly state whether the benefits were promised indefinitely or only for the duration of the CBA.

As noted by plaintiffs in their brief on appeal, other contract language creates a latent ambiguity regarding whether the healthcare benefits are vested. For example, the CBAs contain a "survivor" option permitting continuation of a surviving spouse's health care coverage following the death of the retiree. The fact that this provision contemplates that coverage will continue until, and even after, the death of the retiree indicates that the parties intended that the healthcare coverage would last beyond the three-year term of the individual CBAs. In addition, the CBAs provide that the agreement may be terminated if the retiree fails to enroll in Medicare at age 65. This provision again contemplates that the coverage outlasts the three-year period of the CBA given that a retiree may retire years before turning 65. Furthermore, the CBAs provide that healthcare coverage is suspended while the retiree has coverage through another employer, but then states that coverage through the CBA recommences once the coverage through the other

employer ends. Once again, this contract provision indicates that the parties contemplated that the retirees will receive healthcare benefits far beyond the three-year term of the CBAs. Accordingly, we conclude that the CBAs contain a latent ambiguity with regard to whether the parties intended for the retiree benefits to vest, and the trial court properly examined extrinsic evidence to determine the meaning of the CBAs.

In determining that the healthcare benefits were lifetime benefits, the trial court examined a 2014 bond funding proposal, accompanied by a letter from the Macomb County Executive. We agree with the trial court that this unrefuted evidence established the intent of the parties to provide lifetime healthcare benefits to retirees. The trial court relied on a sentence in the 2014 bond proposal, which read, "The County provides retiree health benefits to eligible County retirees (and their eligible beneficiaries) *for their lifetimes*." (Emphasis added.) The proposal acknowledged that the practice of funding retiree healthcare benefits began 20 years earlier. Additionally, the proposal provided, "*Historically*, Macomb County has offered retiree healthcare to *vested* employees as part of their benefit package." (Emphasis added.)

We conclude that these statements by defendant establish that the healthcare benefits are vested. The first statement expressly provides that the healthcare benefits last for the life of the retiree and the retiree's eligible beneficiaries. The second statement provides that healthcare benefits are granted to employees with vested rights and states that this has been an historical practice of the county. Importantly, the bond proposal outlines defendant's 20-year history of funding the health benefits, suggesting that defendant took this position during the period in which plaintiffs retired and continued to take the same position during the pendency of this case.<sup>1</sup> Accordingly, plaintiffs presented unrefuted evidence establishing that the retiree healthcare benefits are vested.

### III. MODIFICATION OF THE BENEFITS

The next issue is whether the trial court correctly concluded that defendant maintained the ability to modify the healthcare coverage in spite of the fact that the healthcare benefits are vested. We disagree with the trial court's conclusion that defendant could modify the healthcare benefits without plaintiffs' consent.

In *Harper Woods*, this Court clarified that a party to a contract may not unilaterally alter the contract and that when an alteration of a CBA affects a party's vested rights, the change may give rise to a breach of contract action. See *Harper Woods*, 312 Mich App at 508. This Court further rejected the trial court's use of a reasonableness standard to determine whether the defendant properly altered the retirees' healthcare benefits without the consent of the retirees. *Id.* at 508-509. This Court stated, "In Michigan, '[a] mere judicial assessment of "reasonableness" is an invalid basis on which to refuse to enforce contractual provisions.' " *Id.* at 509 (citation omitted; alteration in original). With regard to the trial court's reliance on the "reasonableness"

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<sup>1</sup> In addition to this dispositive evidence, plaintiffs presented evidence that a human resources representative for defendant informed retirees that the healthcare benefits are lifetime benefits.

standard outlined in *Reese v CNH America, LLC*, 694 F3d 681 (CA 6, 2012), this Court explained that “the trial court was not bound to follow *Reese*.” *Id.* This Court further explained,

*Reese* does not stand for the proposition that an employer may always unilaterally alter its retirees’ healthcare benefits under a CBA, regardless of the CBA’s specific language, as long as the alterations are reasonable. Rather, the *Reese* court indicated that a retiree’s right to health insurance benefits under a CBA could be unilaterally altered if evidence indicated the parties intended to permit such alterations, not because vested health insurance benefits under a CBA are unilaterally alterable as a matter of law. [*Id.* at 510.]

Importantly, this Court then added, “Under established contract principles, vested retirement rights may not be altered without the [retiree]’s consent.” *Id.* at 511 (citation and quotation marks omitted; alteration in original).

The exemplar CBAs outline the healthcare benefits provided to retirees. The CBAs describe the healthcare plan provided to the pre-Medicare eligible retirees, but also state that defendant may provide the “substantial equivalence” of the plan. The CBAs explain, “Determination of substantial equivalency, as expressed herein, will be subject to review and agreement by the Parties to this Agreement, prior to implementation of same.” The substantial equivalence caveat only appears with regard to the pre-Medicare eligible retiree healthcare coverage, and the CBAs do not contain similar language with regard to prescription coverage, the “over 65 supplemental” coverage for Medicare-eligible retirees, or the alternative HMO plans. Regardless, defendant failed to provide *any* evidence indicating that plaintiffs consented to the alteration in the healthcare benefits. Therefore, we conclude that the trial court erred by determining that defendant may reasonably modify the scope and level of the healthcare benefits without plaintiffs’ consent. The trial court erred by granting summary disposition in favor of defendant, and summary disposition in favor of plaintiffs was appropriate. Accordingly, we remand this case to the trial court for entry of an order granting summary disposition in favor of plaintiffs and granting plaintiffs’ motion for a permanent injunction in conformance with this opinion.

Affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Kathleen Jansen  
/s/ Karen M. Fort Hood  
/s/ Joel P. Hoekstra

**EXHIBIT B**

**Court of Appeals, State of Michigan**

**ORDER**

Rita Kendzierski v County of Macomb

Docket No. 329576

LC No. 2010-001380-CK

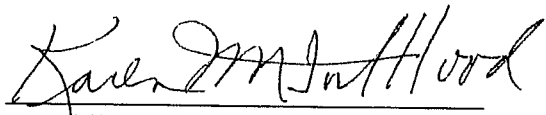
Karen M. Fort Hood  
Presiding Judge

Kathleen Jansen

Joel P. Hoekstra  
Judges

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The Court orders that the motion for reconsideration is DENIED.

  
Presiding Judge



A true copy entered and certified by Jerome W. Zimmer Jr., Chief Clerk, on

**MAY 30 2017**

Date

  
Chief Clerk

**EXHIBIT C**

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(A) (S)

STATE OF MICHIGAN

MACOMB COUNTY CIRCUIT COURT

RITA KENDZIERSKI,  
BONNIE HAINES,  
GREG DENNIS,  
LOUISE BERTOLINI,  
JOHN BARKER,  
JAMES COWAN,  
VINCENT POWIERSKI,  
ROBERT STANLEY,  
ALAN MOROSCHAN and  
GAER GUERBER, on behalf of themselves  
and those who are similarly situated,

Plaintiffs,

Case No. 2010-1380-CK

vs.

COUNTY OF MACOMB,

Defendant.

\_\_\_\_\_ /

OPINION AND ORDER

The parties move for summary disposition and plaintiffs move for a permanent injunction.

I. BACKGROUND

Plaintiffs filed this class action on March 31, 2010 asserting defendant County of Macomb unilaterally changed the retirement healthcare benefits of nearly 2,000 retired employees. As the changes violated several collective bargaining agreements, plaintiffs seek to prevent defendant from changing their retirement healthcare benefits both now and in the future. Plaintiffs also seek damages in the form of their increased costs from the changes in their retirement healthcare benefits.

Accordingly, plaintiffs' complaint alleges breach of contract and seeks injunctive relief.

An *Opinion and Order* dated January 19, 2011 certified this lawsuit as a class action.

On February 2, 2015, plaintiffs moved to bifurcate the issues of liability and damage remedies. An *Opinion and Order* dated February 20, 2015 granted the motion.

The parties now move for summary disposition and plaintiffs move for a permanent injunction.

## II. STANDARD OF REVIEW

In reviewing a motion under MCR 2.116(C)(7), a court will accept the allegations of the complaint as true unless contradicted by documentary evidence. *Pusakulich v City of Ironwood*, 247 Mich App 80, 82; 635 NW2d 323 (2001). The reviewing court must consider any affidavits, depositions, admissions and other documentary evidence submitted by the parties that would be admissible as evidence at trial. *Id.*

A motion for summary disposition under MCR 2.116(C)(8) tests the legal sufficiency of a claim and must be decided on the pleadings alone; all well-pled facts and reasonable inferences drawn therefrom are taken as true. *Markis v Grosse Pointe Park*, 180 Mich App 545, 551; 448 NW2d 352 (1989). The motion should be denied unless the claim is clearly so unenforceable as a matter of law that no factual development could establish the claim and justify recovery. *Id.*

A motion for summary disposition under MCR 2.116(C)(10) tests the factual support for a claim. The reviewing court must consider the pleadings, affidavits, depositions, admissions and other documentary evidence available to it in the light most favorable to the nonmoving party. *Village of Dimondale v Grable*, 240 Mich App 553, 566; 618 NW2d 23 (2000). After a moving party identifies an issue upon which he believes there is no disputed fact and supports that belief with evidence, the nonmoving party must proffer evidence establishing a material issue of disputed fact exists for trial to avoid summary disposition. MCR 2.116(G)(4).

### III. ANALYSIS

#### A. Summary Disposition

Defendant asserts plaintiffs' claim of unalterable lifetime healthcare benefits is barred by the expiration of the prior CBAs and a six-year statute of limitation, their failure to attach the CBAs at issue to their complaint and to specify the CBAs breached, and to prove a breach of any CBA or past practice. Hence, defendant argues it could unilaterally change retiree healthcare benefits.

In response and support of its own motion for summary disposition, plaintiffs aver the six-year statute of limitation does not bar challenges to the unilateral healthcare benefit reductions imposed from 2009-2013, defendant—being a party to the CBAs—was in possession of and did not need to be served copies of the CBAs, the governing CBAs promised a specified Blue Cross/Blue Shield plan or its substantial equivalence for the retiree's lifetime, defendant has admitted that retiree healthcare coverage is a lifetime benefit and the unilateral healthcare benefit reductions breached the CBAs. Thus, plaintiffs argue they are entitled to summary disposition.

Defendant's reply has been considered.

As a preliminary matter, MCR 2.113(F) generally requires a party asserting either a claim or defense based on a written instrument to attach a copy of that instrument to its pleading. Both plaintiffs' complaint and defendant's answer with affirmative defenses rely on the CBAs without attaching the CBAs. Both parties were clearly in possession of the CBAs (alleviating any prejudice from the failure to attach the CBAs) and the bulk of the CBAs—as evidenced by the present attachment of some of the CBAs as an exhibit—made attachment impractical; any error also could have been timely corrected by amendment. MCR 2.118(A) or (B).

The parties acknowledge the CBAs are contracts and subject to a six-year statute of

limitation. MCL 600.5807(8). In *Miller-Davis Co v Ahrens Constr, Inc*, 495 Mich 161, 180; 848 NW2d 95 (2014), the Court stated:

MCL 600.5807(8) provides that “[n]o person may bring or maintain an action to recover damages or sums due for breach of contract...unless, after the claim first accrued..., he commences the action within...6 years....” [Footnote omitted.] The six-year limitation of MCL 600.5807(8) begins to run “when the promisor fails to perform under the contract.” [*Cordova Chem Co v Dep’t of Natural Resources*, 212 Mich App 144, 153; 536 NW2d 860 (1995).]

In the instant matter, plaintiffs claim defendant breached its duty under the CBAs not to alter healthcare benefits. While defendant evidently made unilateral healthcare coverage changes as early as 2003, plaintiffs could not have possibly challenged each later change until those changes were adopted and a claim for breach would have accrued. Therefore, plaintiff may challenge those changes implemented on or after March 31, 2004.

In *M & G Polymers USA, LLC v Tackett*, 574 US \_\_\_\_; 135 S Ct 926, 933; 190 L Ed 2d 809 (2015),<sup>1</sup> the Supreme Court stated:

Welfare benefits plans must be “established and maintained pursuant to a written instrument,” [29 USC] 1102(a)(1), but “[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans,” *Curtiss-Wright Corp v Schoonejongen*, 514 US 73, 78; 115 S Ct 1223; 131 L Ed 2d 94 (1995). As we have previously recognized, “[E]mployers have large leeway to design disability and other welfare plans as they see fit.” *Black & Decker Disability Plan v Nord*, 538 US 822, 833; 123 S Ct 1965; 155 L Ed 2d 1034 (2003). And, we have observed, the rule that contractual “provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA [welfare benefits] plan.” *Heimeshoff v Hartford Life & Accident Ins Co*, 571 US \_\_\_\_; 134 S Ct 604, 611–612; 187 L Ed 2d 529 (2013). \* \*

We interpret collective-bargaining agreements, including those establishing ERISA plans, according to ordinary principles of contract law, at least when those principles are not inconsistent with federal labor policy. See *Textile Workers v Lincoln Mills of Ala*, 353 US 448, 456–457; 77 S Ct 912; 1 L Ed 2d 972 (1957). “In this endeavor, as with any other contract, the parties’ intentions control.” *Stolt-Nielsen SA v Animal Feeds Int’l Corp*, 559 US 662, 682; 130 S Ct 1758; 176 L Ed 2d 605 (2010) (internal quotation marks omitted).

<sup>1</sup>*M&G Polymers* was issued January 26, 2015 and significantly changed the legal landscape regarding whether CBAs can be interpreted to create a vested right to lifetime health care benefits.

“Where the words of a contract in writing are clear and unambiguous, its meaning is to be ascertained in accordance with its plainly expressed intent.” 11 R Lord, Williston on Contracts § 30:6, p. 108 (4th ed 2012) (Williston) (internal quotation marks omitted).

The *M&G Polymers* Court abrogated *UAW v Yard-Man, Inc.*, 716 F2d 1476 (CA 6, 1983), and its progeny, concluding “*Yard-Man* violates ordinary contract principles by placing a thumb on the scale in favor of vested retiree benefits in all collective-bargaining agreements” based on inferences and speculation. 135 S Ct at 935. Instead, a party seeking to utilize customs or usages to determine the meaning of a contract “must prove those customs or usages using affirmative evidentiary support”. *Id.* The *M&G Polymers* Court also observed the need:

to consider the traditional principle that courts should not construe ambiguous writings to create lifetime promises. See 3 A Corbin, Corbin on Contracts § 553, p 216 (1960) (explaining that contracts that are silent as to their duration will ordinarily be treated not as “operative in perpetuity” but as “operative for a reasonable time” (internal quotation marks omitted)). [*Id.* at 936.]

The *M&G Polymers* Court further stated the need:

to consider the traditional principle that “contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement.” *Litton Financial Printing Div, Litton Business Systems, Inc v NLRB*, 501 US 190, 207; 111 S Ct 2215; 115 L Ed 2d 177 (1991). That principle does not preclude the conclusion that the parties intended to vest lifetime benefits for retirees. Indeed, we have already recognized that “a collective-bargaining agreement [may] provid[e] in explicit terms that certain benefits continue after the agreement’s expiration.” *Ibid.* But when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life. [*Id.* at 937.]

The exemplar CBAs from 2000-2004 provided in pertinent part:<sup>2</sup>

Retirees: The employer will provide fully paid Blue Cross/Blue Shield Hospital-Medical coverage to the employee and the employee’s spouse for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees’ Retirement Ordinance, based on the following conditions and provisions:

- a. Coverage shall be limited to the current spouse of the retiree, at the time of

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<sup>2</sup>Any differences in the language, co-pays, employee hire dates or CBA effective dates in the various CBAs submitted for review are not outcome determinative.

retirement.... Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible current spouse receives applicable retirement benefits following the death of the retiree.

- b. Coverage shall be limited to Blue/Cross/Blue Shield MVF1 Master Medical with ML Rider, or its substantial equivalence.
- c. Preferred Rx Managed Prescription Drug Program: An eligible retiree, and the person who is said retiree's spouse at the time of retirement...will be enrolled in the Preferred Rx Management Prescription Drug Program. Coverage is as follows:
  - (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
  - (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
  - (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.
- (d) Retired employees and/or their current spouse, upon reaching age 65, shall apply if eligible, and participate in the Medicare Program at their expense...at which time the Employer's obligation shall be only to provide "over 65 supplemental" hospital-medical benefit coverage.

The exemplar CBAs from 2005-2007, with changes italicized, provided in pertinent part:

Retirees: The employer will provide fully paid Blue Cross/Blue Shield Hospital-Medical coverage to the employee and the employee's spouse, *after eight (8) years of service with the Employer*, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based on the following conditions and provisions:

*Effective January 1, 2006, for all employees hired on or after January 1, 2006, the Employer will provide fully paid hospital-medical coverage to the employee and the employee's spouse, after fifteen (15) years of actual service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based on the following conditions and provisions:*

- a. Coverage shall be limited to the current spouse of the retiree, at the time of retirement.... Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible current spouse receives applicable retirement benefits following the death of the retiree.
- b. Coverage shall be limited to Blue/Cross/Blue Shield MVF1 Master Medical with ML Rider, or its substantial equivalence.
- c. Preferred Rx Managed Prescription Drug Program: An eligible retiree, and the person who is said retiree's spouse at the time of retirement...will be enrolled in the Preferred Rx Management Prescription Drug Program. Coverage is as follows:
  - (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
  - (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
  - (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.

*Effective January 1, 2006, an eligible retiree, and the person who is said retiree's spouse at the time of retirement...will be enrolled in the Preferred Rx Management Prescription Drug Program. Coverage is as follows:*

- (1) *The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.*
- (2) *Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.*
- (3) *Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.*
- (4) *Mandatory Mail-Order for Maintenance Drugs.*
- (d) Retired employees and/or their current spouse, upon reaching age 65, shall

apply if eligible, and participate in the Medicare Program at their expense...at which time the Employer's obligation shall be only to provide "over 65 supplemental" hospital-medical benefit coverage.

The exemplar CBAs from 2008-2010, with additional changes italicized, provided in pertinent part:

Retirees: The employer will provide fully paid Blue Cross/Blue Shield *Preferred Provider Organization (PPO) coverage or its substantial equivalence* to the employee and the employee's spouse, after eight (8) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based on the following conditions and provisions:

For all employees hired on or after January 1, 2006, the Employer will provide fully paid *Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence* to the employee and the employee's spouse, after fifteen (15) years of actual service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based on the following conditions and provisions:

*For all employees hired on or after ratification, the Employer will provide fully paid Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence for the employee's spouse, after twenty (20) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based on the following conditions and provisions:*

*Such employee who retires after fifteen (15) years of service and before twenty (20) years of service with the Employer, will be provided the option of paying for spousal health care under the County group health plan at the time the employee becomes eligible for health care coverage.*

- a. Coverage shall be limited to the current spouse of the retiree, at the time of retirement *or DROP....* Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible current spouse receives applicable retirement benefits following the death of the retiree.
- b. Preferred Rx Managed Prescription Drug Program: *Effective July 1, 1996,* an eligible retiree, and the person who is said retiree's spouse at the time of retirement...will be enrolled in the Preferred Rx Management Prescription Drug Program. Coverage is as follows:

- (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
- (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
- (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.

Effective January 1, 2006, an eligible retiree, and the person who is said retiree's spouse at the time of retirement...will be enrolled in the Preferred Rx Management Prescription Drug Program. Coverage is as follows:

- (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
  - (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
  - (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.
  - (4) Mandatory Mail-Order for Maintenance Drugs.
- (d) Retired employees and/or their current spouse, upon reaching age 65, shall apply if eligible, and participate in the Medicare Program at their expense...at which time the Employer's obligation shall be only to provide "over 65 supplemental" hospital-medical benefit coverage.

There is no ambiguity in the plain language regarding retiree healthcare coverage in the various CBAs. The CBAs only require defendant to provide healthcare coverage to retirees. Defendant did not promise or otherwise obligate itself under the clear language to provide a certain duration or level of retiree healthcare coverage beyond the term of each CBA. Indeed, plaintiffs have not pointed to any specific CBA language explicitly conferring lifetime or

unalterable healthcare benefits on retirees.<sup>3</sup>

Notwithstanding, plaintiffs have proffered unrefuted evidence that defendant has acknowledged that retiree healthcare coverage is a lifetime benefit. The Retiree Healthcare, Capital Improvement Plan, and Downtown Revitalization Funding Proposal issued by Macomb County Executive Mark A. Hackel unmistakably states defendant “provides retiree health benefits to eligible County retirees (and their eligible beneficiaries) for their *lifetimes*”. *Id.* at 28 (emphasis added). Consistent therewith, John Barker testified that Wendy Fisher told him that his retiree medical coverage was a lifetime benefit. Consequently, plaintiffs have proven defendant has a custom of providing lifetime healthcare coverage.

However, plaintiffs have not established defendant has unequivocally acknowledged that it is obligated to provide unalterable retiree healthcare coverage. Eric Herppich testified annual reviews of retiree benefits were conducted but changes would only be made if the changes did not overly burden retirees. As such, he did not testify that changes could not be made. To the contrary, Herppich stated retiree healthcare coverage was historically changed consistent with active employee healthcare coverage. John Patrick Anderson similarly testified the goal in reviewing retiree healthcare coverage to achieve costs savings was to minimize rather than to preclude any changes; the task force was never told changes could not be made.

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<sup>3</sup>Plaintiffs’ reliance on unpublished case law, all of which predate and—with the exception of *Loftis v City of Oak Park*, unpublished opinion per curiam of the Court of Appeals, issued July 24, 2012 (Docket No. 304064)—were superseded by *M&G Polymers*, to otherwise construe the CBAs as providing retirees with lifetime unalterable healthcare coverage is unavailing. In particular, *Genesee County Community Mental Health v Sprague*, unpublished opinion per curiam of the Court of Appeals, issued June 29, 2011 (Docket No. 297490), contained express contractual language that addressed the issue of when a retiree’s entitlement to healthcare benefits vested; the case did not address whether those benefits could be modified. *Bachman v City of Jackson*, unpublished opinion per curiam of the Court of Appeals, issued December 16, 2003 (Docket No. 242087), and *Girardi v City of Sterling Heights*, unpublished opinion per curiam of the Court of Appeals, issued June March 3, 2000 (Docket No. 209640), similarly only addressed contract language regarding the retirees’ entitlement to healthcare benefits. While the *Loftis* Court did address whether retiree healthcare benefits could be modified, it did so under a collective bargaining agreement that required the benefits to “be made available to all retirees...at the same level of coverage that was provided at the time of their separation of employment”. In the instant matter, the subject exemplar CBAs do not contain any promise to maintain the same level of coverage provided at the time of retirement. Accordingly, plaintiffs’ unpublished cases are all distinguishable. The cases also lack precedential value. MCR 7.215(C)(1).

While the Request for Proposal 31-12 notes retiree medical plan commitments—which are not specified—under the CBAs, the RFP clearly states the “*Objectives* are to preserve the current level of coverage”. (Emphasis added.) As a result, the RFP is evidence that defendant considered the level of coverage to be modifiable rather than unalterable. In the same way, defendant’s various acknowledgements of “obligations”, without reference to any specific promise regarding a vested minimum level of retiree healthcare coverage, does not establish defendant has admitted the coverage was unalterable.

Given the lack of evidence of unalterable retiree healthcare coverage after the expiration of the CBAs or that such coverage was changed during the term of the CBAs, defendant could not have breached the CBAs by implementing changes after their expiration. Moreover, defendant’s ability to alter retiree healthcare coverage after expiration of the CBAs defeats plaintiffs’ substantial equivalence argument.<sup>4</sup>

Therefore, retirees have lifetime healthcare benefits but defendant may reasonably modify the scope and level of benefits from those that existed when the retirees retired. *M & G Polymers*, 139 S Ct 926; see also *Reese v CNH America, LLC*, 574 F3d 315, 327 (CA 6, 2009).

#### B. Preliminary Injunction

Having failed to establish the likelihood that they will prevail on their claim for breach of contract, plaintiffs are not entitled to injunctive relief.

#### IV. CONCLUSION

For the reasons set forth above:

A. Defendant County of Macomb’s motion for summary disposition is GRANTED to the

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<sup>4</sup>While not relevant to this determination, defendant correctly notes “substantial equivalence” was limited to hospital-medical coverage provided during the terms of the CBAs. The phrase was not included in or otherwise made applicable to prescription drug coverage and, in any event, does not purport to apply beyond the expiration of each CBA.

extent that it may reasonably modify the scope and level of benefits from those that existed when the retirees retired and

B. Plaintiffs' motion for:

1. Summary disposition is DENIED and
2. A permanent injunction is DENIED.

This *Opinion and Order* resolves the last pending claim in this matter and closes the case.  
MCR 2.602(A)(3).

IT IS SO ORDERED.

Date: September 16, 2015

DMD/wdw

cc: Christopher P. Legghio  
Karen B. Berkery

DIANE M. DRUZINSKI

~~Circuit Court Judge~~  
Hon. Diane M. Druzinski, Circuit Court Judge

SEP 16 2015

**A TRUE COPY**  
CARMELLA SABAUGH, COUNTY CLERK

BY: Patricia K. Jones Court Clerk

**EXHIBIT D**

AGREEMENT

between

COUNTY OF MACOMB

and

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

LOCAL 411

January 1, 2005  
through  
December 31, 2007

AFSCME LOCAL 411 MASTER AGREEMENT

THIS AGREEMENT is entered into on the first day of January, 2005, between the COUNTY of MACOMB, hereinafter referred to as the Employer or the County, and Michigan Council 25, AFSCME, and its affiliated Local Union #411, hereinafter referred to as Union, on behalf of regular employees of duly recognized, and clearly defined classifications in the Departments or Divisions of Departments listed in Appendix B.

The general purpose of this Agreement is to set forth terms and conditions of employment, and to promote orderly and peaceful labor relations for the mutual interest of the Employer and employees and the Union.

ARTICLE 1RECOGNITION OF UNION

Pursuant to and in accordance with all applicable provisions of Act 379 of the Public Acts of 1965, as amended, the Employer does hereby recognize the Union as the exclusive representative for the purpose of collective bargaining in respect to wages, hours of employment, and other conditions of employment for the term of this Agreement of all employees of the Employer included in the classifications in the Departments or Divisions of Departments listed in Appendix B.

ARTICLE 2DEDUCTION OF UNION DUES AND/OR SERVICE FEES

The Employer hereby agrees to deduct fees or service fees of the individual employee to the extent and as authorized by the laws of the State of Michigan and by such employee upon the following terms and conditions:

- A. Each employee who desires to have such dues or service fees deducted from his/her earnings shall execute the AUTHORIZATION FOR DEDUCTION OF UNION DUES form in full.
- B. The Employer shall place such deduction or deductions in effect at the SECOND PAY PERIOD of the month following receipt of same and continue in accordance with the terms and conditions set forth in the Authorization. New employees shall begin paying Union Dues, or Service Fees in-lieu of dues at the second pay period of the month after the employee has completed ninety (90) days of employment.
- C. The Employer shall transmit such deductions, together with a list of the employees paying same, to the Secretary/Treasurer of Michigan AFSCME Council 25 designated in writing by the Union, and shall do so, as soon as possible after the deduction, but not later than the fifteenth day of the following month.
- D. The Employer shall notify the Union of the termination of employment of the dues and/or service fees paying employee or of the revocation, alteration or amendment by the employee of the Authorization to Deduct Union Dues and/or Service Fees in accordance with the terms thereof.
- E. The Authorization for Deduction of Union Dues and/or Service Fees when executed, shall be binding upon the employee for the duration of this Agreement, except that any employee may revoke, alter or amend such Authorization for Deduction of Union Dues and/or Service Fees by notice in writing to the Employer within thirty (30) days, failing in which, the original authorization shall be automatically renewed under the same terms and conditions for the life of the subsequent Agreement.

## ARTICLE 18

INSURANCE BENEFITSA. Life Insurance:1. Active Employees (DROP Participants):

- a. The life insurance death benefit provided by the Employer shall be equal to the employee's annual salary rounded to the nearest thousand dollars and \$4,500 additional accidental death and/or dismemberment (AD&D) benefit. The amount of life insurance shall be computed by using the employees' annual base salary as of January 1st of each year of this Agreement.

The Employer will provide a payroll deduction option for employees wishing to purchase additional death benefit life insurance. The amount of coverage shall be equal to 1, 2, 3, 4 or 5 times the employee's annual salary (rounded to the nearest thousand dollars) and based on the Employer's and individual's combined level of coverage. The amount of life insurance shall be computed by using the employee's annual base salary as of January 1st of each year of this Agreement. Rates and conditions shall be subject to those established by the insurance carrier.

- b. Waiting Period: Employees who are eligible for life insurance benefits will be covered on the first day of the month following sixty (60) days of continuous employment.

2. Retirees: The Employer will provide fully paid Life Insurance coverage, in the amount of two thousand dollars (\$2,000), to employees covered by this Agreement who retire on or after January 1, 1981, and are eligible for and receive benefits under the Macomb County Employees' Retirement Ordinance.

B. Hospital-Medical Insurance:

1. Active Employees (DROP Participants): The Employer shall provide fully-paid Blue Cross/Blue Shield Hospital-Medical coverage, or its substantial equivalence, to all regular employees and their eligible families on the following basis and coverage:

- a. Blue Cross/Blue Shield MVF1, and Master Medical coverage, ML Rider and OB Rider.

Effective January 1, 2006, employees currently enrolled in the Blue Cross/Blue Shield Traditional health care program shall be permitted to maintain this coverage, however, the employee will be required to contribute the difference in cost between the Blue Cross/Blue Shield Traditional program and the Blue Cross/Blue Shield Community Blue PPO program on a monthly basis, through payroll deduction. No employees not currently enrolled in the Blue Cross/Blue Shield Traditional insurance program shall be permitted to enroll in that program.

- b. Waiting Period: Employees who are eligible for hospital-medical insurance benefits will be covered on the first day of the month following sixty (60) days of continuous employment.

- c. Eligible employees covered by the traditional Blue Cross/Blue Shield indemnity health care plan will be enrolled in the Preferred Rx Managed Prescription Drug program and subject to the following terms and conditions:

(1) Co-Pays For Preferred Rx Plan:

- (a) Co-pays for prescriptions received from a Preferred Rx network pharmacy will be \$5.00.

(b) Co-pays for prescriptions received by mail-order will be \$2.00.

(2) The Employer will pay the monthly premium for such coverage for all eligible employees.

Effective January 1, 2006, eligible employees covered by a Blue Cross/Blue Shield health care plan will be enrolled in the Preferred Rx Managed Prescription Drug program and subject to the following terms and conditions:

(1) Co-Pays for Preferred Rx Plan:

(a) Co-pays for prescriptions received from a Preferred Rx network pharmacy will be as follows:

- \$10.00 Co-pay for generic drugs
- \$20.00 Co-pay for non-generic drugs

(b) Co-pays for prescriptions received by mail-order will be \$5.00.

(2) Mandatory Mail-Order for Maintenance Drugs.

(3) The Employer will pay the monthly premium for such coverage for all eligible employees.

d. Active employees, who are covered by Blue Cross/Blue Shield Hospital-Medical coverage, shall be required to participate in Health Care savings known as "Predetermination of Elective Admissions".

e. The Employer shall offer Active employees the option of selecting the "Preferred Provider Organization" program.

Effective January 1, 2006, the Preferred Provider Organization program shall require a \$100 deductible per individual or a \$200 deductible per family annually.

f. The Employer shall begin a program to coordinate and to eliminate overlapping health care coverage. Each employee who chooses to join no County-sponsored health care plans (Blue Cross/Blue Shield, Health Maintenance Organization or Preferred Provider Organization), and whose spouse or parent has coverage provided by another employer, shall be paid \$1,500 each year for every year that the spouse or parent has coverage. Payments of \$750 will be made semi-annually to each employee who has not been on any County-sponsored health care program for six (6) months.

Employees shall be required to show proof annually that a spouse or parent has health care coverage that includes the employee before said employee will be declared eligible to receive the \$1,500 annual payment.

Employees, whose spouse's or parents' health care plans cease to cover the employee, shall be allowed to enroll in a County-sponsored health care plan by showing proof that the spouse's or the parents' coverage has ceased. In such cases, the employee shall be allowed to enroll in a County-sponsored plan at the next billing period.

g. Effective January 1, 2006, the co-payment for non-emergent use of an emergency room shall increase from \$50.00 to \$100.00 for employees covered by all Blue Cross/Blue Shield insurance products.

2. Retirees: The Employer will provide fully paid Blue Cross/Blue Shield Hospital-Medical coverage to the employee and the employee's spouse, after eight (8) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based upon the following conditions and provisions:

Effective January 1, 2006, for all employees hired on or after January 1, 2006, the Employer will provide fully paid hospital-medical coverage to the employee and the employee's spouse, after fifteen (15) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based upon the following conditions and provisions:

- a. Coverage shall be limited to the current spouse of the retiree, at the time of retirement, provided such employee shall retire on or after January 1, 1974. Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible current spouse receives applicable retirement benefits following the death of the retiree.
- b. Coverage shall be limited to Blue Cross/Blue Shield MVF1 Master Medical with ML Rider, or its substantial equivalence.
- c. Preferred Rx Managed Prescription Drug Program: An eligible retiree, and the person who is said retiree's spouse at the time of retirement, covered by the traditional Blue Cross/Blue Shield indemnity health care plan will be enrolled in the Preferred Rx Managed Prescription Drug Program. Coverage is as follows:

- (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
- (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
- (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.

Effective January 1, 2006, an eligible retiree, and the person who is said retiree's spouse at the time of retirement, covered by a Blue Cross/Blue Shield health care plan will be enrolled in the Preferred Rx Managed Prescription Drug program. Coverage is as follows:

- (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
  - (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
  - (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$5.00.
  - (4) Mandatory Mail-Order for Maintenance Drugs.
- d. Retired employees and/or their current spouse, upon reaching age 65, shall apply if eligible, and participate in the Medicare Program at their expense as required by the Federal Insurance Contribution Act, a part of the Social Security Program, at which time the Employer's obligation shall be only to provide "over 65 supplemental" hospital-medical benefit coverage. Failure to

participate in the aforementioned Medicare Program, shall be cause for termination of Employer paid coverage of applicable hospital-medical benefits, as outlined herein for employees who retire and/or their current spouse.

- e. Employees who retire under the provisions of the Macomb County Employees' Retirement Ordinance, and/or their current spouse, who subsequently are gainfully employed, shall not be eligible for hospital-medical benefits, during such period of gainful employment, as hereinafter defined:

Gainful employment is defined as applying to retiree and/or spouse of retiree who are employed subsequent to the employee retirement. If such employment provides hospital-medical coverage for both retiree and spouse, the County is not obligated to provide said coverage unless and until the coverage of either person is terminated. If the coverage is not provided to retiree and spouse, the County will provide hospital-medical coverage for the person not covered.

- f. Employees who retire under the provisions of the Macomb County Employees' Retirement Ordinance and current spouse, shall, if eligible apply for and participate in ANY National Health Insurance program offered by the U.S. Government. Failure to participate, if eligible, shall be cause for termination of Employer paid hospital-medical benefits as outlined.
- g. Retirees who are covered by Blue Cross/Blue Shield Hospital-Medical coverage, shall be required to participate in Health Care savings known as "Predetermination of Elective Admissions".
- h. The Employer shall offer retirees the option of selecting the "Preferred Provider Organization" program.
- i. The Employer shall begin a program to coordinate and to eliminate overlapping health coverage. Each retiree who chooses to join no County-sponsored health care plans (Blue Cross/Blue Shield, Health Maintenance Organization or Preferred Provider Organization), and whose spouse has coverage provided by another employer, shall be paid \$1,500 each year for every year that the spouse has coverage. Payments of \$750 will be made semi-annually to each retiree who has not been on any County-sponsored health care plan for six (6) months.

Retirees shall be required to show proof annually that a spouse has health care coverage that includes the retiree before said retiree will be declared eligible to receive the \$1,500 annual payment.

Retirees whose spouse's health care plans cease to cover the retiree, shall be allowed to enroll in a County sponsored health care plan by showing proof that the spouse's coverage has ceased. In such cases, the retiree shall be allowed to enroll in a County-sponsored plan at the next billing period.

C. Health Maintenance Organization:

1. Active Employees (DROP Participants): The Employer will provide a Health Maintenance Organization option for regular employees covered by the present hospital-medical surgical program under this Insurance Section of this Agreement, provided the premium does not exceed the cost of the present insurance.
2. Waiting Period: Employees who are eligible for hospital-medical insurance benefits will be covered on the first day of the month following sixty (60) days of continuous employment.
3. Retirees: The Employer will provide a Health Maintenance Organization option for current and future retirees of the bargaining unit, provided the premium does not exceed the cost of the present insurance.

A retiree will have the option of retaining his/her HMO coverage at time of retirement or converting from Blue Cross/Blue Shield to HMO coverage during the County's annual open enrollment period.

- D. Dental Insurance: A Dental Insurance Program will provide the following:
1. Employees (DROP Participants) covered by this Agreement and their dependents will be covered by a 75/25 Class I, 50/50 Class II, maximum \$1,000.00 per year, per person, Delta Dental Plan, or its substantial equivalence with the Employer paying the premium for said coverage.
  2. Waiting Period: Employees hired on or after January 1, 1981, who are eligible for dental benefits will be covered on the first day of the month following six (6) months of continuous employment.
- E. Optical Program: An Optical Insurance Program will provide the following:
1. Employees (DROP Participants) covered by this Agreement and their dependents will be covered by a Blue Cross/Blue Shield Vision Care Program known as Series A80, or its substantial equivalence.
  2. Waiting Period: Employees who are eligible for optical benefits will be covered on the first day of the month following sixty (60) days of continuous employment.
- F. Liability Insurance: The County shall provide for each regular employee (DROP Participant) Bodily Injury and Property Damage Liability Insurance while acting within the scope of his/her duties and Personal Injury Insurance including "false arrest" when also arising out of and in the line of duty and in the conduct of duly constituted Employer business. The cost of this insurance will be borne by the Employer.
- G. Long Term Disability: Employees (DROP Participants) covered by this Agreement will be provided a Long Term Disability program with benefits as currently provided by the present provider, or its substantial equivalence.
- H. Determination of substantial equivalency, as expressed herein, will be subject to review and agreement by the Parties to this Agreement, prior to implementation of same.
- I. Short Term Disability: The Employer will provide a payroll deduction option for employees (DROP Participants) wishing to purchase Short Term Disability Insurance that may be provided by the Union.
- The Union agrees that it will protect, indemnify and save harmless the Employer from any and all claims, demands, suits and other forms of liability, in any manner or fashion related to said short term disability insurance, including but not limited to, the existence of coverage, the extent of coverage, the qualification for benefits and any other issue with the exception of proper Employer compliance with the written payroll deduction authorization of the employee.
- J. Part-Time Employees Insurance Benefits: Effective as soon as practicable after ratification of this Agreement, part-time employees, except as provided in Appendix C, Paragraph D.1., will be eligible to purchase Group Hospital, Medical, Optical, Dental and/or Group Life Insurance coverage through the County at 100% employee expense.

#### ARTICLE 19

#### RETIREMENT SYSTEM

- A. Retirement Benefits: The Employer shall continue the benefits as provided by the presently constituted Macomb County Employees' Retirement Ordinance, and the Employer and the employee shall abide by the terms and conditions thereof, provided, that the provisions thereof may be amended by the Employer as provided by the

ARTICLE 39TERMINATION OR MODIFICATION

- A. This Agreement shall continue in full force and effect until December 31, 2007.
- B. If either party wishes to terminate or modify this Agreement, said party shall provide written notice to the other party to that effect. Said notice shall be made no later than one hundred twenty (120) days prior to the termination date in Paragraph A., above. If neither party gives a notice of termination or modification, or if each party giving notice of termination or modification withdraws said notice prior to the termination date in Paragraph A., above, this Agreement shall continue in full force and effect from year to year thereafter, subject to timely notice of termination or modification by either party in subsequent year(s) of an extended Agreement.
- C. Notice of termination or modification shall be made in writing and shall be sent by Certified Mail. If said notice is made to the Union, it shall be sent to Michigan AFSCME Council 25, 28000 Van Dyke Avenue, Suite 102, Warren, Michigan 48093; if said notice is made to the County, it shall be sent to the Macomb County Director, Human Resources, County Building, 10 N. Main Street, Mount Clemens, Michigan, 48043; address changes shall be made available to the other party, where applicable.

**EXHIBIT E**

AGREEMENT

between

COUNTY OF MACOMB

and

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

LOCAL 411

January 1, 2008  
through  
December 31, 2010

AFSCME LOCAL 411 MASTER AGREEMENT

THIS AGREEMENT is entered into on the first day of January, 2008, between the COUNTY of MACOMB, hereinafter referred to as the Employer or the County, and Michigan Council 25, AFSCME, and its affiliated Local Union #411, hereinafter referred to as Union, on behalf of regular employees of duly recognized, and clearly defined classifications in the Departments or Divisions of Departments listed in Appendix B.

The general purpose of this Agreement is to set forth terms and conditions of employment, and to promote orderly and peaceful labor relations for the mutual interest of the Employer and employees and the Union.

ARTICLE 1RECOGNITION OF UNION

Pursuant to and in accordance with all applicable provisions of Act 379 of the Public Acts of 1965, as amended, the Employer does hereby recognize the Union as the exclusive representative for the purpose of collective bargaining in respect to wages, hours of employment, and other conditions of employment for the term of this Agreement of all employees of the Employer included in the classifications in the Departments or Divisions of Departments listed in Appendix B.

ARTICLE 2DEDUCTION OF UNION DUES AND/OR SERVICE FEES

The Employer hereby agrees to deduct fees or service fees of the individual employee to the extent and as authorized by the laws of the State of Michigan and by such employee upon the following terms and conditions:

- A. Each employee who desires to have such dues or service fees deducted from his/her earnings shall execute the AUTHORIZATION FOR DEDUCTION OF UNION DUES form in full.
- B. The Employer shall place such deduction or deductions in effect at the SECOND PAY PERIOD of the month following receipt of same and continue in accordance with the terms and conditions set forth in the Authorization. New employees shall begin paying Union Dues, or Service Fees in-lieu of dues at the second pay period of the month after the employee has completed ninety (90) days of employment.
- C. The Employer shall transmit such deductions, together with a list of the employees paying same, to the Secretary/Treasurer of Michigan AFSCME Council 25 designated in writing by the Union, and shall do so, as soon as possible after the deduction, but not later than the fifteenth day of the following month.
- D. The Employer shall notify the Union of the termination of employment of the dues and/or service fees paying employee or of the revocation, alteration or amendment by the employee of the Authorization to Deduct Union Dues and/or Service Fees in accordance with the terms thereof.
- E. The Authorization for Deduction of Union Dues and/or Service Fees when executed, shall be binding upon the employee for the duration of this Agreement, except that any employee may revoke, alter or amend such Authorization for Deduction of Union Dues and/or Service Fees by notice in writing to the Employer within thirty (30) days, failing in which, the original authorization shall be automatically renewed under the same terms and conditions for the life of the subsequent Agreement.

- a. A leave of absence may be requested because of illness/injury suffered by a member of the employee's immediate family. The term immediate family as used in this section shall mean current spouse, parents, grandparents, children, brothers or sisters of the employee or of the employee's current spouse. It shall also include any person who is normally a member of the employee's household. All requests for this type of leave of absence must be submitted in writing to the Department Head or designee. In proper circumstances, the Employer may waive the requirement that said request be in writing.
  - b. In addition to the written request for a leave of absence, a letter from the physician attending the ill/injured member may be requested to evaluate the request.
- 3. Education:
  - a. All requests for this type of leave of absence shall be submitted in writing to the Department Head or designee.
  - b. All requests for this type of leave of absence must be submitted at least thirty (30) days prior to the effective date of leave.
- 4. Personal Reasons:
  - a. All requests for this type of leave of absence shall be submitted in writing to the Department Head or designee.
  - b. All requests for this type of leave of absence must normally be submitted at least thirty (30) days prior to the effective date of leave.

#### ARTICLE 18

##### NOTICE OF MILITARY SERVICE

The Employer complies with the Uniform Services Employment and Reemployment Right Act (USERRA), 38 USC, Chapter 43 Employment and Reemployment Rights of Members of the Uniformed Services. An employee whose absence from employment is necessitated by reason of duty in the uniformed services, shall notify the Department Head or designee of the upcoming military service requirements.

Benefits provided for employees absent under this Article shall be provided consistent with the Uniform Services Employment and Reemployment Right Act (USERRA), 38 USC, Chapter 43 Employment and Reemployment Rights of Members of the Uniformed Services and/or current policy as approved by the Board of Commissioners.

#### ARTICLE 19

##### INSURANCE BENEFITS

#### A. Life Insurance:

##### 1. Active Employees (including DROP Participants):

- a. The life insurance death benefit provided by the Employer shall be equal to the employee's annual salary rounded to the nearest thousand dollars and \$4,500 additional accidental death and/or dismemberment (AD&D) benefit. The amount of life insurance shall be computed by using the employees' annual base salary as of January 1st of each year of this Agreement.

The Employer will provide a payroll deduction option for employees wishing to purchase additional death benefit life insurance. The amount of coverage shall be equal to 1, 2, 3, 4 or 5 times the employee's annual salary (rounded to the nearest thousand dollars) and based on the Employer's and individual's combined level of coverage. The amount of life insurance shall be computed by using the employee's annual base salary as of January 1st of each year of this Agreement. Rates and conditions shall be subject to those established by the insurance carrier.

- b. Waiting Period: Employees who are eligible for life insurance benefits will be covered on the first day of the month following sixty (60) days of continuous employment.
- 2. Retirees: The Employer will provide a death benefit, in the amount of two thousand dollars (\$2,000), to employees covered by this Agreement who retire on or after January 1, 1981, and are eligible for and receive benefits under the Macomb County Employees' Retirement Ordinance.

B. Hospital-Medical Insurance:

- 1. Active Employees (including DROP Participants): The Employer shall provide fully paid Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence and Health Maintenance Organization (HMO) coverage or its substantial equivalence to all regular employees and their eligible family members, including prescription drug coverage, as outlined in Appendix D.

Employees who have a spouse employed with Macomb County, will be entitled to one insurance plan for both employees and all dependants. Such employee shall not be eligible for the benefit listed in section B.1.b.

Effective as soon as possible after ratification, employees will no longer be eligible for Traditional Blue Cross Blue Shield coverage.

- a. Waiting Period: Employees who are eligible for hospital-medical insurance benefits will be covered on the first day of the month following sixty (60) days of continuous employment.

Any regular employee laid off and subsequently returned to work, will be eligible for employer-paid insurance coverage as soon as administratively possible after the date of his/her return to work.

- b. Each employee who elects not to participate in any County-sponsored health care plan and who has coverage provided by another employer, shall be paid \$1,500 annually. Pro-rated payments up to \$750 will be made semi-annually to each employee who has not been enrolled in any County-sponsored health care program.

Employees shall be required to show proof annually of coverage from another employer that includes the employee before said employee will be declared eligible to receive payment in lieu of coverage.

Employees, whose spouse's or parents' health care plans cease to cover the employee, shall be allowed to enroll in a County-sponsored health care plan by showing proof that the spouse's or the parents' coverage has ceased. In such cases, the employee shall be allowed to enroll in a County-sponsored plan as soon as administratively possible and the payments in lieu of coverage shall cease as soon as administratively possible.

2. Retirees: The Employer will provide fully paid Blue Cross/Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence to the employee and the employee's spouse, after eight (8) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based upon the following conditions and provisions:

For all employees hired on or after January 1, 2006, the Employer will provide fully paid Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence to the employee and the employee's spouse, after fifteen (15) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based upon the following conditions and provisions:

For all employees hired on or after February 27, 2009, the Employer will provide fully paid Blue Cross Blue Shield Preferred Provider Organization (PPO) coverage or its substantial equivalence for the employee's spouse, after twenty (20) years of service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance, based upon the following conditions and provisions:

Effective on or after February 27, 2009, an employee who retires after fifteen (15) years of service and before twenty (20) years of service with the Employer, will be provided the option of paying for spousal health care under the County group health plan at the time the employee becomes eligible for health care coverage.

- a. Coverage shall be limited to the current spouse of the retiree, at the time of retirement or DROP, provided such employee shall retire on or after January 1, 1974. Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible current spouse receives applicable retirement benefits following the death of the retiree.
- b. Preferred Rx Managed Prescription Drug Program: An eligible retiree, and the person who is said retiree's spouse at the time of retirement, covered by the traditional Blue Cross/Blue Shield indemnity health care plan will be enrolled in the Preferred Rx Managed Prescription Drug Program. Coverage is as follows:
  - (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
  - (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.
  - (3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$2.00.

Effective January 1, 2006, an eligible retiree, and the person who is said retiree's spouse at the time of retirement, covered by a Blue Cross/Blue Shield health care plan will be enrolled in the Preferred Rx Managed Prescription Drug program. Coverage is as follows:

- (1) The employee leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.
- (2) Co-pays for prescriptions received from an approved Blue Cross/Blue Shield Preferred Rx network pharmacy will be \$5.00.

(3) Co-pays for maintenance prescriptions, received from an approved Blue Cross/Blue Shield Preferred Rx provider by mail-order, will be \$5.00.

(4) Mandatory Mail-Order for Maintenance Drugs.

- c. Retired employees and/or their current spouse, shall apply and participate in the Medicare Program, if eligible, at their expense as required by the Federal Insurance Contribution Act, a part of the Social Security Program, at which time the Employer's obligation shall be only to provide "over 65 supplemental" hospital-medical benefit coverage. Failure to participate in the aforementioned Medicare Program, shall be cause for termination of Employer paid coverage of applicable hospital-medical benefits, as outlined herein for employees who retire and/or their current spouse.
- d. Employees who retire under the provisions of the Macomb County Employees' Retirement Ordinance, and/or their current spouse, who subsequently are gainfully employed, shall not be eligible for hospital-medical benefits, during such period of gainful employment, as hereinafter defined:

Gainful employment is defined as applying to retiree and/or spouse of retiree who are employed subsequent to the employee retirement. If such employment provides hospital-medical coverage for both retiree and spouse, the County is not obligated to provide said coverage unless and until the coverage of either person is terminated. If the coverage is not provided to retiree and spouse, the County will provide hospital-medical coverage for the person not covered.

- e. Employees who retire under the provisions of the Macomb County Employees' Retirement Ordinance and current spouse, shall, if eligible apply for and participate in ANY National Health Insurance program offered by the U.S. Government. Failure to participate, if eligible, shall be cause for termination of Employer paid hospital-medical benefits as outlined.
- f. The Employer shall offer retirees the option of selecting the "Preferred Provider Organization" program.
- g. Each retiree who is eligible for hospital medical insurance and elects not to participate in any County-sponsored health care plan and who has coverage provided by another employer, shall be paid \$1,500 annually. Pro-rated payments up to \$750 will be made semi-annually to each retiree who has not been on any County-sponsored health care plan.

Retirees shall be required to show proof annually that a spouse has health care coverage that includes the retiree before said retiree will be declared eligible to receive the \$1,500 annual payment.

Retirees whose spouse's health care plans cease to cover the retiree, shall be allowed to enroll in a County sponsored health care plan by showing proof that the spouse's coverage has ceased. In such cases, the retiree shall be allowed to enroll in a County-sponsored plan at the next billing period.

C. Health Maintenance Organization (see Appendix D):

- 1. Active Employees (including DROP Participants): The Employer will provide a Health Maintenance Organization option for regular employees covered by the present hospital-medical surgical program under this Insurance Section of this Agreement, provided the premium does not exceed the cost of the present insurance.

Employees who have a spouse employed with Macomb County, will be entitled to one insurance plan for both employees and all dependants. Such employee shall not be eligible for the benefit listed in section B.1.b.

2. Waiting Period: Employees who are eligible for hospital-medical insurance benefits will be covered on the first day of the month following sixty (60) days of continuous employment.

Any regular employee laid off and subsequently returned to work, will be eligible for employer-paid insurance coverage as soon as administratively possible after the date of his/her return to work.

3. Retirees: The Employer will provide a Health Maintenance Organization option for current and future retirees of the bargaining unit, provided the premium does not exceed the cost of the present insurance.

A retiree will have the option of retaining his/her HMO coverage at time of retirement or converting from Blue Cross/Blue Shield to HMO coverage during the County's annual open enrollment period.

D. Dental Insurance: A Dental Insurance Program will provide the following:

1. Employees (including DROP Participants) covered by this Agreement and their dependents will be covered by a 75/25 Class I, 50/50 Class II, maximum \$1,000.00 per year, per person, Delta Dental Plan, or its substantial equivalence with the Employer paying the premium for said coverage.
2. Waiting Period: Employees who are eligible for dental benefits will be covered on the first day of the month following six (6) months of continuous employment.

Any regular employee laid off and subsequently returned to work, will be eligible for employer-paid dental insurance coverage as soon as administratively possible after the date of his/her return to work.

E. Optical Program: An Optical Insurance Program will provide the following:

1. Employees (including DROP Participants) covered by this Agreement and their dependents will be covered by an Blue Cross/Blue Shield Vision Care Program known as Series A80, or its substantial equivalence.
2. Waiting Period: Employees who are eligible for optical benefits will be covered on the first day of the month following sixty (60) days of continuous employment.

Any regular employee laid off and subsequently returned to work, will be eligible for employer-paid optical insurance coverage as soon as administratively possible after the date of his/her return to work.

F. Liability Insurance: The County shall provide for each regular employee (including DROP Participant) Bodily Injury and Property Damage Liability Insurance while acting within the scope of his/her duties and Personal Injury Insurance including "false arrest" when also arising out of and in the line of duty and in the conduct of duly constituted Employer business. The cost of this insurance will be borne by the Employer.

G. Long Term Disability: Employees (including DROP Participants) covered by this Agreement will be provided a Long Term Disability program with benefits as currently provided by the present provider, or its substantial equivalence.

- H. Determination of substantial equivalency, as expressed herein, will be subject to review and agreement by the Parties to this Agreement, prior to implementation of same.
- I. Short Term Disability: The Employer will provide a payroll deduction option for employees (including DROP Participants) wishing to purchase Short Term Disability Insurance that may be provided by the Union.

The Union agrees that it will protect, indemnify and save harmless the Employer from any and all claims, demands, suits and other forms of liability, in any manner or fashion related to said short term disability insurance, including but not limited to, the existence of coverage, the extent of coverage, the qualification for benefits and any other issue with the exception of proper Employer compliance with the written payroll deduction authorization of the employee.

- J. Part-Time Employees Insurance Benefits: Effective January 1, 2006, part-time employees, except as provided in Appendix C, Paragraph D.1., will be eligible to purchase Group Hospital, Medical, Optical, Dental and/or Group Life Insurance coverage through the County at 100% employee expense.

## ARTICLE 20

### RETIREMENT SYSTEM

- A. Retirement Benefits: The Employer shall continue the benefits as provided by the presently constituted Macomb County Employees' Retirement Ordinance, and the Employer and the employee shall abide by the terms and conditions thereof, provided, that the provisions thereof may be amended by the Employer as provided by the statutes of the State of Michigan and provided further, that an annual statement of employee's contributions will be furnished to the employee.
- B. Employee Contribution: For any employee hired on or before December 31, 2001 or who is vested as of February 27, 2009, the employee's contribution to the retirement system is three and five tenths percent (3.5%) of his/her compensation.

For employees hired on or after January 1, 2002 the employee's contribution to the retirement system is two and five tenths percent (2.5%) of his/her compensation.

- C. County Pension Maximum: For any employee hired on or before December 31, 2001 or who is vested as of February 27, 2009, the County pension shall not exceed sixty-five percent (65%) of an employee's final average compensation.

For employees hired on or after January 1, 2002, the County pension shall not exceed sixty-six percent (66%) of an employee's final average compensation.

- D. Pension Multiplier: For any employee hired on or before December 31, 2001 or who is vested as of February 27, 2009, the pension multiplier is two and four tenths percent (2.4%) for the first twenty-six (26) years of credited service and one percent (1%) for each year of credited service thereafter.

For employees hired on or after January 1, 2002, the pension multiplier is two and two tenths percent (2.2%) for all years of service.

- E. Final Average Compensation Formula: For any employee hired on or before December 31, 2001 or who is vested as of February 27, 2009, the formula for computing final average compensation, used for calculating pension benefits for eligible bargaining unit members, shall be based on the average of an employee's four (4) highest consecutive years of compensation out of the last ten (10) years of service.

IN WITNESS WHEREOF, the County of Macomb and its Board of County Commissioners, by its Director, Human Resources, and representatives of Michigan AFSCME Council 25 and Local 411, on behalf of its represented employees, hereby cause this Agreement, Supplement and Appendices to be executed.

FOR THE UNION:

FOR THE COUNTY OF MACOMB:

Dorra Conger  
Cynthia Hudson  
Ellen Keith  
Joyce Campa  
Janice Wilson  
Cesario Hart

Linda Ruppert

Dated: 10-4-10

# Community Blue<sup>SM</sup> PPO Plan 6

## Benefits-at-a-Glance – Macomb County Proposal 2008



This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

**In-network****Out-of-network****Deductible, copays and dollar maximums**

**Note:** Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

<b>Deductible</b>	\$250 for one member, \$500 for the family per calendar year <b>Note:</b> Deductible waived if service is performed in a PPO physician's office.	\$500 for one member, \$1,000 for the family per calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Copays</b>		
• Fixed dollar copays	\$20 for office visits and \$100 for emergency room visits	\$100 for emergency room visits
• Percent copays	10% for general services, waived if service is performed in a PPO physician's office, and 50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
<b>Copay dollar maximums</b>		
• Fixed dollar copays	None	None
• Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	\$1,000 for one member, \$2,000 for two or more members per calendar year	\$2,000 for one member, \$4,000 for two or more members per calendar year <b>Note:</b> Out-of-network copays also apply toward the in-network maximum.
<b>Dollar maximums</b>	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services	

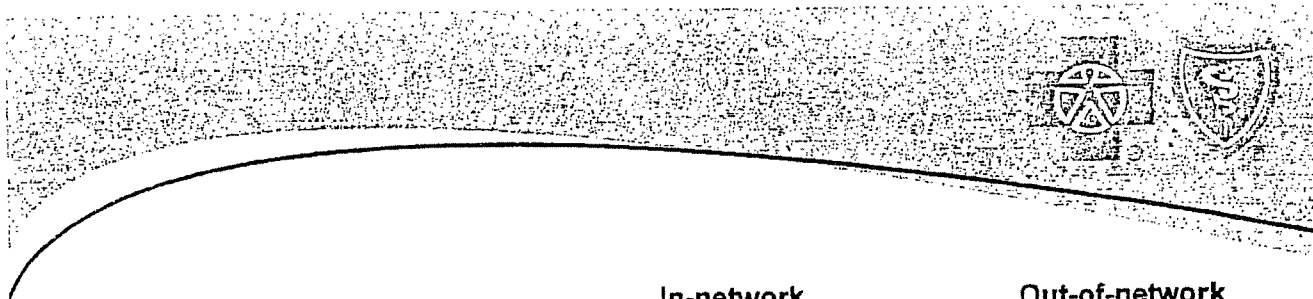
**Preventive care services – \*Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year**

Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

**Mammography**

Mammography screening	Covered – 90% after deductible	Covered – 80% after deductible
	One per calendar year, no age restrictions	

Blue Cross Blue Shield of Michigan is an equal opportunity employer and a member of the Blue Cross of Michigan Association.



	In-network	Out-of-network
Physician office services		
Office visits	Covered – \$20 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 90% after deductible	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – \$20 copay	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – \$20 copay	Covered – 80% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	Covered – \$100 copay, waived if admitted or for an accidental injury	Covered – \$100 copay, waived if admitted or for an accidental injury
Ambulance services – medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Diagnostic services		
Laboratory and pathology services	Covered – 90% after deductible	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 90% after deductible	Covered – 80% after deductible
Therapeutic radiology	Covered – 90% after deductible	Covered – 80% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 90% after deductible	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 90% after deductible	Covered – 80% after deductible
	Unlimited days	
Inpatient consultations	Covered – 90% after deductible	Covered – 80% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 80% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 90% after deductible	Covered – 90% after deductible
	Up to 120 days per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Home infusion therapy – medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Surgical services		
Surgery – includes related surgical services	Covered – 90% after deductible	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 90% after deductible	Covered – 80% after deductible
Voluntary sterilization	Covered – 90% after deductible	Covered – 80% after deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 90% after deductible	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 90% after deductible	Covered – 80% after deductible
Kidney, cornea and skin	Covered – 90% after deductible	Covered – 80% after deductible

**Mental health care and substance abuse treatment**

	In-network	Out-of-network
Inpatient mental health care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Outpatient mental health care		
• Facility and clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount that is adjusted annually	

**Other covered services**

Outpatient Diabetes Management Program (ODMP)	Covered – 90% after deductible	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic spinal manipulation	Covered – 100%	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 90% after deductible	Covered – 80% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 90% after deductible	Covered – 90% after deductible
Prosthetic and orthotic appliances	Covered – 90% after deductible	Covered – 90% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription drugs	Not covered	Not covered

**Optional riders**

Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	MOD: \$400 for one member, \$750 for two or more members per calendar year
Preventive care services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year	MOD: Payment for preventive services is limited to a combined maximum of \$750 per member per calendar year
Mammography screening	MOD: Covered – 100% after deductible
Allergy testing and therapy	MOD: Covered – 100% after \$10 co-pay
Chiropractic spinal manipulation	MOD: Covered – 100% after \$10 co-pay
Prescription drugs	MOD: \$5 Generic / \$25 Formulary / \$50 Non-Formulary
Prescription drugs – Mail Order	MOD: 2 times retail \$10 Generic / \$50 Formulary / \$100 Non-Formulary
Contraceptive Injections	CI
Prescription Contraceptive Devices	PCD
Prescription Contraceptive Medications	PD-CM
Exclusion of benefit for voluntary abortion	XVA

## Appendix D- Insurance Benefits Plan Designs

## County of Macomb Plan Option as modified below (HAP)

Benefit	
Office Visit Primary Physician	\$10
Office Visit Specialist	\$20
Emergency Room Care	\$150
Urgent Care Visit	\$30
Prescription Drugs	
Generic	\$5
Formulary	\$15
Non-formulary	\$25
Mail-Order	2 X above co-pay

## County of Macomb Plan Option as modified below (BCN)

Benefit	
Office Visit Primary Physician	\$10
Office Visit Specialist	\$20
Emergency Room Care	\$150
Urgent Care Visit	\$30
Prescription Drugs	
Generic	\$5
Formulary	\$15
Non-formulary	\$25
Mail-Order	2 X above co-pay